[LB431 LB466 LB574]

The Committee on Health and Human Services met at 1:30 p.m. on Friday, February 4, 2011, in Room 1510 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on LB431, LB574, and LB466. Senators present: Kathy Campbell, Chairperson; Mike Gloor, Vice Chairperson; Dave Bloomfield; Tanya Cook; Gwen Howard; Bob Krist; and Norm Wallman. Senators absent: None. []

SENATOR CAMPBELL: Good afternoon and welcome to the Health and Human Services Committee. I'm Senator Kathy Campbell. I serve as the Chair for this committee and I represent the 25th Legislative District. We'll go ahead and introduce my colleagues on the committee and start with my far right. []

SENATOR BLOOMFIELD: I'm Dave Bloomfield. I serve Dakota, Dixon, and Wayne Counties in northeast Nebraska. []

SENATOR WALLMAN: Norm Wallman, District 30, from south Lincoln to the Kansas border. []

MICHELLE CHAFFEE: I'm Michelle Chaffee, legal counsel to the committee. []

SENATOR HOWARD: Senator Gwen Howard, District 9 in Omaha, called the "Sunshine District." Don't you love it? (Laugh) []

SENATOR KRIST: Even when it's not. Senator Bob Krist. I serve the 10th Legislative District, northwest Omaha, primarily. []

SENATOR CAMPBELL: And to my far left is Diane Johnson who serves as clerk for the committee, and behind is Crystal. Crystal is the page today for us and is a senior. Next year will be looking for jobs so will be talking to all of you. (Laughter) I want to go through just a few housekeeping things and then we'll start. I would like you to silence your cell phones so that you don't bother your neighbor or anybody in the committee, particularly don't bother the clerk with any noise because then you're in trouble. We would ask that you have 12 copies of your testimony, if you're providing written. And if you do not have them, the pages will direct you as to where you could get additional copies. We would ask that you sign in on a sign-up sheet, and I think they're bright orange, only if you're going to testify. So when you come forward, before you sit down, if you would give your handouts and your sign-in sheet to the clerk, that would be particularly helpful. We are on a timing mechanism here. It's five minutes, so it will be green for a long time, and then all of a sudden it will be yellow, and then you won't believe how fast it goes to red. And that's when I'll be going, time, time, time, time. Please, when you sit down, before you start your testimony, give us your full name and spell the last name for us. And with that, we will open the public hearing this afternoon

on LB431. But before that, joining us is Senator Cook. Welcome. Senator Hadley's bill on adopt the Health Care Quality Improvement Act, and welcome, Senator Hadley. First time here. [LB431]

SENATOR HADLEY: Yes, thank you, Senator Campbell. Such an august group. I'm happy to be here and honored that you would listen. My name is Galen Hadley, that's G-a-l-e-n H-a-d-l-e-y. I represent the 37th District. That's the county of Kearney and the city of Kearney. And I'm here to talk about LB431. As we know, in healthcare, quality improvement is paramount. When you talk to...I know some of you have served on boards on hospitals and you know that that is the paramount concern of a hospital board is quality improvement. And one of the ways that we have tried to improve healthcare is through peer review. A lot of different organizations now use peer review as a way to improve quality, whether it's an educational unit or other types of units, it's your peers looking at what you're doing and making a judgment on it. And we have that. It's very common now in hospitals to have peer review. It may go by many different names, but it's basically peers looking at their peer fellows as to what kind of situations have been incurred, and what we can do to change any possible situations that have occurred, so we don't have reoccurrences of situations. LB431 is intended to update the existing peer review laws so that hospitals and other healthcare providers are encouraged to conduct medical peer review to monitor and improve patient care. Medical peer review promotes improved patient safety by providing an environment where facilities of the individual providers feel safe reporting and analyzing adverse health events. Nebraska's health peer review law was passed in 1971 and has not been updated since. The Legislature passed a separate law for health clinics and other outpatient practices sites in 1997, and a statewide Patient Safety Improvement Act in 2005. LB431 would consolidate and broaden the two peer review laws and bring them into harmony with the Patient Safety Improvement Act. There is a need to expand the types of committees and activities that come within the protection of the peer review laws. Because of the way the 1971 law was written, the courts have construed it very narrowly and limited the types of activities which are considered peer review. This legislation makes clear that hospitals and other health providers can conduct quality assessment activities, conduct honest utilization reviews, and root cause analysis and similar events. LB431 contains...retains provisions in the current peer review law that protect persons who participate in the peer review process from civil liability for acts and decisions within the scope of the functions, and protect peer review records from being used in civil litigation. The next part is exceedingly important. LB431 also retains the provision in current law that participants in civil actions will have access to patient's medical records, documents, or information otherwise available from the original sources. This is not a law that is trying to hide the original sources. To put it in another way, this law is basically the idea that peer review committees, or whatever the name they go by, can gather data from these original sources, analyze it, and come up with recommendations to improve healthcare quality and patient's safety. It doesn't protect those original documents, but what it does is protect what the peer review committee

comes up with. And I think that's an important distinction that we're not trying to limit what can be obtained from the original documents. With that, I would be happy to answer any questions the committee might have. We do have a number of testifiers for the proposal from the medical area. [LB431]

SENATOR CAMPBELL: Questions? Senator Wallman. [LB431]

SENATOR WALLMAN: Thank you, Senator Campbell. Welcome here, Senator Hadley. [LB431]

SENATOR HADLEY: I'm happy to be here, Senator Wallman. [LB431]

SENATOR WALLMAN: You know, I've read this thing over and I'm still reading it over again, but you...is there any protection for the patient here? [LB431]

SENATOR HADLEY: Oh, I believe so, Senator Wallman. I think that protection is just what I talked about. The fact that the original documents, the original incident reports are available to a plaintiff's attorney through discovery. This does not, in anyway, limit that...that is available. But what it does limit is that if the peer review committees take these....all of these documents and analyze them, and then come up with recommendations to improve patient safety, it protects that part of the process from discovery. I liken it, and I'm not a lawyer, but I liken it. It seems to me that the lawyers could be saying, well, we'll just wait until the peer review committee does all their work and then we'll just ask for that in discovery and we don't have to connect the dots. We'll have the hospital connect the dots for us. The problem with doing that is that then people get gun shy in the peer review committees. If you know that you can...what you say or do in the peer review committee can end up being discovered and forced to testify in a court of law, you might say, well, I'm not going to take part of that peer review because of that. I hope that makes sense. [LB431]

SENATOR WALLMAN: That makes sense. Let's take it one step further. [LB431]

SENATOR HADLEY: Okay. [LB431]

SENATOR WALLMAN: Okay. What if our state institutions, like the prisons, our regional centers, you know, like BSDC, was there any protection here for the workers? You know, patients can lie. [LB431]

SENATOR HADLEY: Oh, I think that's correct. I would guess that the normal tort system would, hopefully, if a patient is lying in our correctional systems, would root out that it is a lie and that false charges are being made against our medical providers. But I don't believe the medical providers in a corrections institute are...have any more or less protection than a physician who is practicing at St. Elizabeth's Hospital. [LB431]

SENATOR WALLMAN: Thank you, Senator. [LB431]

SENATOR CAMPBELL: Senator Krist. [LB431]

SENATOR KRIST: Senator Hadley. Thank you, Chairperson. I guess, you know, reducing it to something that I understand, that was my question, and I don't know that you want to answer it or that someone behind you will, but when you're doing an accident investigation in the NTSB, you really can't get the answers you need without protecting the people who are giving you the feedback and providing testimony, so. I'm looking forward to hearing if that is indeed the case because that's one of the things that I took away from this change is that there is some protection there and because of that, you will get full disclosure if it parallels that NTSB analogy that I used. [LB431]

SENATOR HADLEY: I think that would be a very good analogy, Senator Krist, and I think someone...let me make one thing perfectly clear. Right now, the law says we can have two committees, a peer review and a...I forgot the name of the other one. But they're basically at the hospitalwide level and they have protections. What my...what this bill says, if you take the University of Nebraska Medical Center, you know they have large departments. Right now, a peer review committee in their surgery department may not have protection under our current law for doing root cause analysis. Or if they have a tissue committee, will not have protection under our current laws because the court case delineated that there can only be two committees hospitalwide. And what my bill does, it says, if we're willing to allow them to be protected at the hospitalwide level, why can't we have the same protection for the surgery department, the tissue committee, whatever the department might be. [LB431]

SENATOR KRIST: Thank you, Senator. Thank you, Chair. [LB431]

SENATOR CAMPBELL: Any other questions from the senators? Thank you, Senator Hadley. [LB431]

SENATOR HADLEY: Thank you. [LB431]

SENATOR CAMPBELL: Will you be staying for closing? [LB431]

SENATOR HADLEY: I will stay and listen, but I'll probably waive closing. [LB431]

SENATOR CAMPBELL: Okay. Thank you very much. Could we have a show of hands of how many proponents there are for the bill who wish to testify? Okay. How many wish to testify in opposition to the bill? One. Okay. And anyone in the hearing room who wants to provide neutral testimony? All right. We'll start with the first proponent for the bill. How are you, Doctor? [LB431]

LESLIE SPRY: (Exhibit 1) Very well. Good afternoon, Chairwoman Campbell and members of the committee. Thank you for being here this afternoon and listening to our concerns in this regard. My name is Leslie Spry, and that's L-e-s-l-i-e, Spry, S-p-r-y, and I am a kidney specialist here in Lincoln, Nebraska. I'm the past president of the Nebraska Medical Association and I am the Nebraska delegate to the American Medical Association. I'm here on behalf of the Nebraska Medical Association to testify in favor of LB431 as introduced by Senator Hadley. This bill improves patient safety and will lead to lower costs and more efficient medical care by updating peer review laws in the State of Nebraska as you heard from Senator Hadley. I'm a past chief of the St. Elizabeth's Regional Medical Center here in Lincoln and, as such, I witnessed peer review efforts that could have been more diligent and comprehensive if we could have had greater participation by other members of the medical staff. As Senator Hadley mentioned, there are only two committees that are sanctioned or at least that have sanction under case law in Nebraska, and that does not even begin to address the number of peer review type of activities that go on in medicine today. I also witness hospital attorneys place significant limitations on the extent of review because of concerns about discovery related to malpractice and legal risk that could be raised as a result of medical staff members' participation in peer review. I also recently was deposed as an expert witness in a lawsuit where the issue of my professional activity as a medical director at a dialysis unit, and the peer review incumbent on performing my duties as a medical director, were questioned. I did not answer the question, but my right not to answer this question was challenged during the proceeding. The goal of peer review is to achieve better outcomes at lower costs by carefully examining medical errors, medical mistakes, and so-called "near misses." Root cause analysis and careful investigations by physicians and other members of the medical care team are critical to getting meaningful analysis that can be used to educate physicians and other members of the medical care team. As processes of care are identified, one can usually find some reason why that process of care broke down and led to an error or a near miss. As I have come to learn, there are many layers in the process of care, and trying to put systems and policies in place so that adverse patient outcomes and medical errors do not occur, is a complex endeavor. Medicine by its very nature is complex, and the more people involved with greater and greater complexity of systems, the more opportunities for error to occur. In today's climate of healthcare, we are trying to learn from the United States space program, and as Senator Krist mentioned, the international aviation, that fault must not be assigned in order to get at the truth of any system. Hold harmless disclosure is imperative for patient safety and safety of the flying public. All participants must give forthcoming and truthful answers without fear of discipline or legal entanglements. That is not to say that original details and documentation of medical mishaps cannot be discovered and reviewed by attorneys. Indeed, under this act, all medical records, documents, and information otherwise available from original sources and kept with respect to any patient in the ordinary course of business, shall be available for discovery. One of the most complex areas where peer review is currently needed is in

the process of transition of care. Whenever a patient is transferred from one venue of care to another venue of care, there are many pitfalls that may occur. These can lead to medical errors and costly rehospitalization. There are many new examples of patient movements between care organizations, such as dialysis units, in my own case, that are currently not protected under the laws pertaining to peer review, and need to be. Accountable care organizations that are envisioned in the new healthcare law will be very complex examples of coordinated patient care that must be subject to peer review. In summary, peer review in medical care not only occurs in hospitals, but should occur in each and every patient care encounter. This review must be diligent and aggressive. In order to get accurate information and allow healthcare professionals to be forthcoming, this process needs to be protected from the entanglements of legal discovery. We need to know, who knew what, where, and when, in order to improve patient safety and improve overall medical care. Thank you, and I'm available to answer any questions that you may have. [LB431]

SENATOR CAMPBELL: Questions from the senators for Dr. Spry? Dr. Spry, would you agree with Senator Hadley that the overall committees in a hospital may be protected, but it's really the smaller committees where you have seen some...just not quite a feeling that they can be forthright? [LB431]

LESLIE SPRY: Again, the more complex the care, the more need for this kind of review because the layers and layers of process that occur and the two committees are credentials committee and utilization review, currently, and under that, you can have protection from peer review. But if you get into, let's say, the process of care that goes on in delivering care in the intensive care unit, or if you go on to transition that's occurring now on a daily basis where you go from hospital care to nursing home care to the dialysis unit, in my circumstance, that care is difficult to review. I, as the medical director of the dialysis unit, reviewed that care and again my ability to not answer questions in regards to peer review, was questioned as a result of a legal process. And so when legal counsel tells me, don't do that because of fear of discovery, that really hampers the opportunity to provide that kind of care and review the care that was administered. [LB431]

SENATOR CAMPBELL: Exactly. Senator Krist. [LB431]

SENATOR KRIST: I didn't have a question, but I have a comment. Even if you change the law, having spent as many years as I have in another industry, there will be a cultural change that has to happen with the people who are involved at the level that you want to get the truth from to make the positive changes. So, hopefully, this legislation is the kind of legislation that will go through because it sounds like it's needed. We'll continue to listen to it, but you have the challenge now of changing the culture, because... [LB431]

LESLIE SPRY: We have 25 years as postchallenger to learn what they learned then. [LB431]

SENATOR KRIST: Absolutely. Good point. [LB431]

SENATOR CAMPBELL: Any other questions or comments? Thank you, Dr. Spry. The next proponent. Good afternoon. [LB431]

DENISE DESTACHE: (Exhibits 2 and 3) Good afternoon. My name is Denise Destache, my last name is spelled D-e-s-t-a-c-h-e, and I'm a litigation attorney at Lamson, Dugan and Murray law firm in Omaha, Nebraska. My practice is primarily in medical malpractice defense, and so I, and others at my firm, represent physicians, hospitals, and other healthcare providers in cases in which they have maybe been sued for negligence. And we also provide advice, more general advice to hospitals and healthcare providers on issues related to healthcare such as privilege related to the peer review function. I'm here on behalf of the Nebraska Medical Association in support of LB431, introduced by Senator Hadley. Both of the speakers that went before me, I thought, did an excellent job of pointing out the importance of peer review and the importance of the privilege that attends that. As a practitioner, I think I would like to focus on what I see dealing with hospitals and healthcare providers, and how LB431 would change the existing law. The current Nebraska law was written quite a while back and they're written very narrowly and have been interpreted by the Nebraska Supreme Court very narrowly. And as you heard earlier that the privilege given to the peer review committees are only given to one hospitalwide medical staff committee and one hospitalwide hospital committee. There's no privilege for any subcommittees under those committees, so care cannot be reviewed on a unit-based level. This is impractical in today's hospitals where specialization has increased so much. There's so many different specialities and new technologies available all the time that for one committee to be charged with reviewing all of the medical subspecialties and all of the care provided that are brought to the committee is just not very feasible anymore. I've handed out an example...well, I handed out two things. One is a summary of my talk and the other one is an example of a hospital committee structure. And this was an actual one for one of the hospitals that I represented that has since been changed. Let me see. It's not unusual, it's like other hospital committee structures. And as you can see, there is no hospitalwide medical staff committee or hospitalwide utilization review committee. The medical peer review committee is a subcommittee of two other committees which both have some function in the peer review process. And then under the peer review committee, down at the bottom of your chart, you'll see a line of about 13 different peer review committees, one for each of the different medical departments. And this is how hospitals want to practice. This is how they feel the peer review process would be best enhanced by performing peer review on a departmental level where you have surgeons reviewing surgery care, and anesthesiologists reviewing anesthesia care, and talking about it among each other so that they can come to a consensus

about whether something went wrong, and what they can do to prevent that from happening again. In the one large hospitalwide committee, there may be one member of each department as well as maybe a chief medical officer, so you don't really get as much of several people coming from one department. Under the current Nebraska law, incidents reports and other reports to medical committees may not be protected. In the current LB431, there would be some protection for incident reports and other documents being reported to the peer review committees. That's important because you want people to be comfortable going to them to discuss or to report behavior issues among colleagues, or issues regarding care. And if they don't feel like their report to the committee will be protected from discovery in a lawsuit, you'll have a lot less people reporting those issues. Hospitals and physicians believe the peer review process is essential. All of the hospitals and physicians that we've worked with, they want to do more of it, but they feel held back by the current laws. And I don't think that was what was intended when these laws were enacted. Obviously, our Legislature believes that the privilege is an important thing for the peer review process. But in the manner that it's enacted now, it's not being performed. And I think LB431 will give committees and healthcare providers that comfort in knowing that they can speak openly and honestly without the risk of being brought into litigation or their statements being discovered in other ways. [LB431]

SENATOR CAMPBELL: Questions? Senator Wallman. [LB431]

SENATOR WALLMAN: Thanks, Denise, for being here. Okay, I'm going to give you a scenario here. Say I have a clinic. [LB431]

DENISE DESTACHE: Okay. [LB431]

SENATOR WALLMAN: And I've started this clinic and I'm the chief surgeon. All right, my peers say that I'm getting a little shaky with the scalpel, and they write me up, you know, and they're going to have a hard time, you know, putting me out of the medical profession. So what would you do then if I'd take it to...who would I take it to? [LB431]

DENISE DESTACHE: If the hospital committee is saying that they think... [LB431]

SENATOR WALLMAN: If I had my own clinic. [LB431]

DENISE DESTACHE: If you have your own clinic and who... [LB431]

SENATOR WALLMAN: Who would my peers take it to? Say, who would Senator Krist go to? [LB431]

DENISE DESTACHE: Oh, I see. Well, see that was not a part of the old laws and that's something that we're trying to work into the new laws. How that affects hospital clinics

exactly and, you know, I'm not sure of the answer to that question in a clinic setting. I could answer it for a hospital setting because there's always an appeal process in that situation. But for a clinic, I'm not sure. [LB431]

SENATOR WALLMAN: Sorry. Thanks. [LB431]

SENATOR CAMPBELL: Any other questions? Thank you very much for your testimony today. [LB431]

DENISE DESTACHE: Thank you. [LB431]

SENATOR CAMPBELL: The next proponent. [LB431]

JAN BAHM: (Exhibit 4) Senator Campbell, members of the committee. Hello. My name is Jan Bahm, and that's spelled J-a-n B-a-h-m and I'm a registered nurse who resides in District 25. I'm here to represent myself and the Nebraska Nurses Association, which is the voice for approximately 30,000 registered nurses across Nebraska. We are here to ask your support for LB431. I am currently retired. However, I was last employed by the Nebraska Health and Human Services System as a quality improvement coordinator. With that being said, I am personally aware of the importance of this bill at the professional level. According to the Institute of Healthcare Improvement, there is a gap between what we know and what we do. In other words, healthcare providers and institutions know what they're supposed to be doing. They think they are doing it, but somehow the system breaks down and that's not really what takes place. There are two sayings in this business: (1) if you keep doing the same old thing, you'll keep getting the same old results. (2) If it's not broke, don't fix it. This is where the Healthcare Quality Improvement Act comes into play. It is imperative that we have peer review activities in order to evaluate the outcomes of the healthcare provided, thus, enabling us to make changes for improvement. It is our hope that LB431 will make healthcare providers less fearful of both internal and external peer review since the findings will be held in confidence and shall only be used for quality improvement activities. As well, LB431 has made it very clear that reviewers are not liable for any of their findings, making it much easier for internal reviewers to participate and to be honest about their findings. LB431 will assist those in the healthcare system to strive for excellence, thus improving the quality of life for all. Making improvements in healthcare will be extremely important as we try to meet just a few of healthcare's challenges such as, over 125,000,000 people in the United States live with some kind of chronic condition. Chronic diseases account for 70 percent of all deaths in the United States. Chronic diseases account for one-third of the years of potential life lost before age 65. The medical costs of people with chronic diseases account for more than 60 percent of the nation's medical care costs. The direct cost of caring for people with chronic conditions in the United States is over $150 billion per year. This bill has the potential to make a tremendous impact as we push for quality improvement in healthcare. Please support LB431. With that, I'll be glad to take

questions. [LB431]

SENATOR CAMPBELL: Thank you, Ms. Bahm, Questions from the senators? I guess that there are no questions for you today. [LB431]

JAN BAHM: Thank you. [LB431]

SENATOR CAMPBELL: Other proponents who wish to testify in favor of this bill? Opponent testimony? I believe there was a gentleman...oh, it was a lady in the back. I couldn't see whose hand was up. Good afternoon. [LB431]

MANDY STRIGENZ: Good afternoon, Senator Campbell and members of the committee. My name is Mandy Strigenz. My first name is spelled M-a-n-d-y. My last name is spelled S-t-r-i-g-e-n-z. I am here on behalf of the Nebraska Association of Trial Attorneys. I am their current president and I am a practicing attorney in Omaha, Nebraska. I have represented individuals since 1993 in a number of capacities. I also happen to have seven members of my family that are physicians. I've worked on medical malpractice cases. My office has also represented physicians in slander and libel lawsuits against institutions because of credentialing committee issues. So I feel like I have a good background to discuss this bill here with you today. And first of all, let me state that I understand the need for peer review committees. I am certainly in favor of them as I do represent injured patients all the time and, clearly, patient safety is important. I think that peer review committees make sense with the respect to the issue of patient safety, and I think as a society we all value public safety, and also we value the accountability of our healthcare institutions. Keep in mind here today that some testimony has been had about litigation and lawsuits and lawyers and such, but essentially this is not about lawyers. This is about patients, and no patient goes to a lawyer unless someone has been careless and someone has been injured. If a mistake at a hospital has been made, then absolutely those hospitals should be allowed to privately analyze the situation and make corrections so that it does not happen again without fear that everything they say will eventually be discoverable or open to public scrutiny. However, we must be careful not to overreach and give too much power to those committees, because otherwise our plans for patient's safety and hospital accountability will backfire. If a mistake is made that results in serious patient injury or death, and that mistake is the result of negligence, then obviously the recourse is to file the lawsuit. But if we give an overly broad measure of protection to the healthcare providers, it will be impossible for that patient to be able to prove their case. So does this bill overreach and, therefore, compromise public safety? Yes, it does in several important areas. Number one, the peer committee phrase is defined too broadly. If you look in Section 7, it essentially uses the phrase "other committee." And this essentially goes to Senator Wallman's concern that he raised earlier in that really any two people from any healthcare institution under this bill can get together and say, hi, we're the safety committee. And then from that point forward anything that is done by that

committee is now protected and top secret. And I don't think that's what we want in terms of revamping the peer review situation as it stands in Nebraska here today. Again, we're not saying that something doesn't need to be done perhaps to include those subcommittees, but the way the bill is currently written is just not the best way to go about that because it's too overly broad, and that is going to cause problems for patients on down the road. For example, you could have a situation where your elderly mother goes to visit you in the hospital because you've broken your leg. She slips and falls on a puddle of water outside the door and becomes injured, she will now have a very difficult time bringing any sort of negligence action against that institution for even a slip and fall claim if that incident is analyzed by any two people from that institution, because the way this bill is currently written, that's all going to be top secret information. So that's just one example of how this could be overly broad. Also the bill contains numerous immunity provisions as has been discussed here today. The problem with that is that you're essentially giving free rein for anyone in those committees to say whatever we want...whatever they want, and it doesn't have to be truthful, and they will never be open to being sued for libel or slander. And I'm surprised there aren't some doctors or individual nurses here today testifying against the bill because those individuals could have their credentials revoked, they could have jobs taken away based upon things that are said in committee about them that are untruthful and that they will never be able to find out about. So that, in and of itself, is a problem. By giving somebody an immunity, an absolute immunity from suit, you are essentially taking away all responsibility of that institution to hold itself accountable. And I can answer questions, if you have any. [LB431]

SENATOR CAMPBELL: Senator Krist. [LB431]

SENATOR KRIST: There's that immunity word again. (Laughter) Did you talk with Senator Hadley or did your organization talk to him as they were...as he was coming to Final? [LB431]

MANDY STRIGENZ: I personally did not talk to the Senator. I don't know if anybody from our organization talked to him about the drafting of the bill. Again, it's not...and maybe to say that we're an opponent is too strong. There's a lot of problems with it. Again, I don't want to come here and say that peer review, in and of itself, is completely worthless. It's not. But it has to be narrowly tailored and that's why the courts have narrowly tailored peer review for 30 years. [LB431]

SENATOR KRIST: And I understand you're not a registered lobbyist, nor do you have an obligation, but just a broad statement. It's great when we senators start to draft these bills if there are issues that can be solved during the drafting process. My second point would simply be in question, actually, would be, are you familiar with the NTSB process and the open exchange of information that happens during an investigation or in an accident or an incident having to do with federal aviation? [LB431]

MANDY STRIGENZ: I have not handled any federal aviation cases, no, I haven't. [LB431]

SENATOR KRIST: Okay. Thank you. [LB431]

SENATOR CAMPBELL: Any questions? Senator Howard. [LB431]

SENATOR HOWARD: I agree with our senator here. We have heard a lot about a...limiting individual's rights. It just seems to be a theme right now. It's very troubling to me if we put anymore restrictions on an individual looking to redress what they see as a problem. I'm well aware that this state has severe limits on how cases...I'm trying...I'm grappling with how to say this, but we're not a liberal state in terms of awarding judgments or encouraging lawsuits or in any of those. I would say that we're really conservative in that respect. And it sounds to me like from what you say, this would further restrict people from bringing in a suit because the information just wouldn't be available. It would be concealed, and I think you make a really good point. I'm glad you came in to share this. [LB431]

MANDY STRIGENZ: Yes, Senator, it really does make it very difficult during the pendency of the civil lawsuit to try and get information from the get-go, but then to even have that further barrier in front of you, and to expand it in this broad of a scope, I think is really dangerous. I think you're really creating a scenario where all sorts of things are now going to be sort of behind the locked door and I, as an individual, coming in from the outside not knowing how these hospital committees are set up, or who's who, or what's what, that just becomes very difficult. All I know is, I have somebody in my office who has been hurt and they need some help. [LB431]

SENATOR HOWARD: I appreciate that. Thank you. [LB431]

MANDY STRIGENZ: Yeah. [LB431]

SENATOR CAMPBELL: In your experience, have you found that hospitals have a due process procedure set up that peer review is a part of that due process? So if a peer was...called it a disciplinary action, that there would be further due process? [LB431]

MANDY STRIGENZ: I do believe as Ms. Destache indicated, that there is an appeal process in some situations. Really, you have two things that work here, I think, with the bill. You have the credentialing aspect of it which has to do with the healthcare providers and everything going on with their jobs and their licenses. You also have the peer review aspect of it which has to do with when a mistake is made at the hospital and somebody is injured. So there's really two separate things going on here that this bill affects. It could really effect the physicians and the nurses and they're livelihood.

And again by giving absolute immunity to those committees, you're really...if one doctor doesn't like another doctor, and he decides, I want to get rid of this guy, and he's on the peer review committee and he brings in his friends on the...and they could have all kinds of discussions about somebody else in their hospital, and completely torpedo that person's career. There's absolutely no recourse for that doctor whatsoever now to be able to come back and say, hey, what did you say about me? What was said? Why did I lose my job? Why am I not getting my credentials? So that's a problem. [LB431]

SENATOR CAMPBELL: I guess I'm calling that into question because I would assume that some hospitals have a due process system whereby a person who may feel that way can appeal it and have a hearing. [LB431]

MANDY STRIGENZ: Possibly, but again, if you're going to give complete confidentiality to what happened in that peer review committee, all that committee is going to...they'll just invoke the privilege. They'll invoke this bill and say, sorry, can't help you. It's top secret. [LB431]

SENATOR CAMPBELL: Is there peer review, a system set up for attorneys? [LB431]

MANDY STRIGENZ: No. [LB431]

SENATOR CAMPBELL: And I'm not saying that...(Laughter) Don't get ahead of me here. I'm not saying that facetiously. I'm just...I'm interested whether there's any internal within the bar association. [LB431]

MANDY STRIGENZ: Again, kind of two separate things. There's, you know, the issue of, has an attorney done something wrong. Well, okay, in that case, then you make the complaint to the ethics board that licenses Nebraska attorneys. In the situation of, has the attorney done something to injure or harm one of their clients, then that client's recourse is just like in a medical malpractice case. And so, no, in that situation there's really not a peer review committee because some law firms are big and some law firms are one person, so. [LB431]

SENATOR CAMPBELL: So in the judicial disciplinary system, however, when a team of people are brought together to review that complaint, do you know whether that group of people has immunity? [LB431]

MANDY STRIGENZ: I don't know the answer to that. I don't believe they do, but I couldn't state you for sure without looking at the statute and reviewing that portion of it. [LB431]

SENATOR CAMPBELL: And I have to say, in all honesty, I've sat on those but I don't know. I mean, I was, honestly questioning. It would be something that probably we

ought to look at because it might be a formula that other professions use for a peer review. [LB431]

MANDY STRIGENZ: That's true. I will tell you I do sit on the Judicial Qualifications Committee, which is probably similar...is that what the committee that you were previously...? [LB431]

SENATOR CAMPBELL: No, it's a disciplinary. [LB431]

MANDY STRIGENZ: Okay, for the attorneys. I sit on the one for the judges. I, as a committee member, I will just tell you. I, as a committee member, on that committee, I don't feel I should have immunity from liability by sitting on that committee. I shouldn't. If I say something that is libelous or slanderous regarding one of our Nebraska judges, I'm going to take responsibility for that. I should have to take responsibility for that. I don't expect to be immune from liability merely because I have the privilege of sitting on that committee. I think I take that with great responsibility and I better do a job that is good and right, and if I don't do a job that is good and right, then you should have the right to come sue me. That's what our legal process is all about. [LB431]

SENATOR CAMPBELL: Any further questions? Thank you very much. [LB431]

MANDY STRIGENZ: Okay. Thank you. [LB431]

SENATOR CAMPBELL: Thanks for coming today. Anyone else in the hearing room who would like to testify in opposition? Anyone who wishes to testify in a neutral position? Seeing no one, Senator Hadley, would you like to close? [LB431]

SENATOR HADLEY: I would like to close now, if I could. I would like to just reiterate a couple of things again. One, LB431 retains the provision in current law. The participants in civil actions will have access to patients' medical records, documents, or information otherwise available for original sources. Remember earlier, I said, what a peer review committee can do is to take these original sources and try to connect the dots to make sure that they can improve healthcare for future patients. And, I guess, I'm concerned if we want to limit immunity and make that discoverable, if I'm a trial attorney, I think that's great, because I don't want to have to look at original documents then. I just wait until the peer review committee looks at them and then I use discovery to find out what they...how they connected the dots and use it. So again, it does not give any immunity or hold from discovery access to patient's medical records, documents, or information otherwise available from the original source. Secondly, after spending, you know, nine years on a hospital board, and reading about this, I will guarantee you most hospitals have due process. And there have been numerous court cases that have found in the favor of doctors who have been terminated for wrongful reasons. That is not uncommon. A particular court case I read about had a doctor who was on staff,

employed by the hospital, left the hospital to set up a competing practice, the hospital used their credentialing process to deny him privileges. It was taken to court and he won. So I think the idea that you can, you know, go through a witch hunt behind closed doors to fire medical professionals, I just don't believe that is done. Secondly, at least in the healthcare organizations I was involved in, this eventually became a board decision where you did sit as a member of the board to hear both sides of the issue. And to say that a board would have...you know, I find it hard to believe that a board would be involved in illegal activities to terminate a physician surprises me. Again, I think the bottom line, and we just heard it, is you have an individual that's been injured, the person that slipped visiting their patient, there would be an incident report written about it. That would be available to the person and their attorney. The hospital can't hide that. And we have to also look at the betterment of the system. If we continually try to make it very difficult to do peer review, honest peer review, you're not going to have changes in outcomes that improve patient safety, patient care and patient outcomes. I think that's the goal. I don't believe this is a bill to try and protect hospitals from an immunity standpoint. I see it as a bill to try and improve patient safety, healthcare, and health outcomes. [LB431]

SENATOR CAMPBELL: (Exhibits 5-7) Senator Hadley, just for the record, we did receive letters of support for LB431 from the Nebraska Hospital Association, from the Nebraska Dental Association, and from Alegent Health. [LB431]

SENATOR HADLEY: Thank you. [LB431]

SENATOR CAMPBELL: Thank you. With that, we will close the hearing on LB431. And we will open the hearing on LB574, Senator Price's bill on adopt the Electronic Prescription Transmission Act. [LB574]

SENATOR PRICE: I know how to clear a room. (Laughter) That's good. [LB574]

SENATOR CAMPBELL: Well, not really everybody. [LB574]

SENATOR PRICE: No, really. [LB574]

SENATOR CAMPBELL: There's a lot of people interested in this bill, Senator Price. Good afternoon. How are you? [LB574]

SENATOR PRICE: I'm well, Senator Campbell. Thank you. Thank you very much. Are we ready for this now? [LB574]

SENATOR CAMPBELL: We are ready. [LB574]

SENATOR PRICE: Thank you very much, Chairman, Chairwoman, Chairperson

Campbell. I'm not sure exactly how you'd like to be addressed, but I will pay attention. [LB574]

SENATOR CAMPBELL: That's fine. You're fine. [LB574]

SENATOR PRICE: Thank you. And to the members of the Health and Human Services Committee. My name is Scott Price, S-c-o-t-t- P-r-i-c-e, and I represent the 3rd Legislative District and I'm here today as a primary introducer of LB574. LB574 adopts the Electronic Prescription Transmission Act. The purpose of the bill is to standardize electronic prescribing and prior authorization in an effort to improve efficiency and enhance patient outcomes. LB574 allows physicians to electronically transmit a prescription directly to a pharmacy of the patient's choosing without interference or limitation prior to the transmission to the pharmacists. All available drug information regarding the patient's insurance plan would be available to the physician and an electronic prior authorization process would be available for allowing approval of an exception to the plan formulary in real time. LB574 also states that a prescription drug or a transmitted by electronic transmission to a pharmacy or pharmacist shall be transmitted without interference by a third party on a neutral...and done on a neutral and open platform that does not use any means, including advertising, instant messaging, or pop-up messages to influence the prescription ordered. An electronic prior authorization process required by this bill allows for the approval of an exception to the health plan providing for real time adjudication. LB574 also creates an advisory committee to the Department of Health and Human Services to provide input on prior authorization standards. Now it has come to my attention that LB574 could have some fiscal impact beyond the $42,000 stated in the fiscal note. I want the committee to know that it was not my intention to capture any part of Medicaid when I introduced LB574. And there will be people behind me who will talk more to this. All right. And I'll spend a few moments now after my prepared statement. Now we'll get into some why's and wherefore's, okay, just so the body doesn't get too inundated by the dryness. Today, billions of electronic transactions take place around the world every day. I can be in my wife's car, she's driving, and I can make a financial transaction on my Blackberry on Highway 2, in most places. I can change my reservations on an aircraft. I can do all sorts of different things electronically, secure. Billions of dollars go through our banks here in Nebraska, or nearly billions, at least lots of money in transactions go through our different banks. So I would think that the transactions we're trying to talk about in LB574 would be allowed to take place as well. And I also bring up, this is an effort that has been ongoing at the national level and we're doing it here. And one of the concerns that we may hear expressed is about waiting until some national standard comes up. Let's wait. Let's sit out here and wait. And I'll tell you of a personal experience of my own. Back in the days when I was active duty and we were moving to computer systems to do weather forecasting and create products, you know, you had program management. I'm pretty sure Senator Krist would be able to illuminate more so on these things. But the program takes a while. You have to make decisions along the way. And there was a file format

called appendix 30. And there are a lot of file formats of how you would see a representation on the screen. And no one knew what it was going to be. So eventually a program manager made a decision, appendix 30. And the system was developed to work with this appendix 30 format. Well, along comes this little upstart called JPEG and GIF. Now most of you probably aren't familiar with appendix 30, but you probably know what a JPEG or a GIF file is. Well, they chose the wrong one, and millions of dollars went the wrong way, and it took a long time to recover from that. So as we go about this process in LB574 and in determining how we do e-prescription more, we already do it. It's already done. It's just not wholesale and there are a lot of things to be worked out. I would encourage that Nebraska be at the table deciding the outcomes and not have an outcome brought to us, forced on us, and just be waiting and then have to be reactive. So I tell you this because I think it's in the best interest of Nebraska and I want to say, in the final paragraph, that the most important thing to me is the patient, and then the patient doctor, what they're doing. And we shouldn't have entities outside of that unnecessarily burdening the process. Now nobody wants that and I'm sure that everybody can come to the table and wants to do the best. But one of the issues we see is there's a paper process in here and that's why I bring this forward. And everything we do, we can break it down into three basic issues, in my mind. We have a policy, we have platform, and we have a business rhythm. And where I want to focus in, is in the platform, the medium. I don't want us to mess with the policies. Good people have worked long and hard to make policies that help the system work to one of the finest medical systems in the world. But when we get to the medium, where we sit there and saying in a paperless world, I see we're all paperless now, that we're relying on the injection of paper into an automatic process. And, thereby, our business rhythm is being impacted. So please don't focus on policy, but look more at the medium about where we're going and how we're going to get there. And where is Nebraska going to be? Are we going to be on the end of the tail of the dog waiting to see what we get handed? Are we going to be at the table creating and formulating the standards to which we later are going to have to live by? So with that, I'd close my testimony and also let you know there are going to be people behind me who are much more articulate in the particular matters, but I would try to answer any questions you have. [LB574]

SENATOR CAMPBELL: Senator Wallman. [LB574]

SENATOR WALLMAN: Thank you, Chairwoman Council, Campbell, I mean. Sorry. (Laughter) And welcome here, Senator Price. You know, I went to a drug thing this morning on drugs...on drug abuse things in the Capitol here. And this had to do with electronic transfer of illegal drugs...legal drugs. It's legal. So on the East Coast, east corridor, people are making millions of dollars on this kind of thing by distributing drugs to people and to teenagers. It's delivered by the mail, FedEx, UPS, and do you think there's enough safeguards in there to stop this? These are literally doctors that should maybe be disbarred. I mean, you know, lose their accreditation, but it's perfectly legal what they're doing. [LB574]

SENATOR PRICE: I think, Senator Wallman, we may have a situation here where we are mixing different things together here. No, it should not be allowed. Yes, there should be repercussions if you're doing something...if the word illegal is involved in it, there's repercussions. Let's not make...let's not mince any words. However, e-prescription happens today. It happens in a lot of places. The question is, the multiple areas where they come up with different standards. And what we want to be able to do is, and I'll simplify it, and, hopefully, I don't offend the people behind me, but the doctor sitting there with their widget, whatever that widget is, and they sit there and say, listen, you know, you're an asthmatic so you need some Singulair, and some Advair and maybe a little Prednisone for the inflammation and you need a little something like this. And they're going to say to you, and they're going to look at their device and find out what medications are right for you, and they're going to say to you, what pharmacy are you going to? They're not going to tell you which one you go to. Meanwhile, these will be medications that these doctors, these formularies that these doctors are using that they understand the protocols. Now if it's something that they're not used to, there will be another set of alerts that will come along because alert fatigue is a challenge here. But they should be able to sit there with their widget, like we do when we pull up our Chamber viewer. How many of us go to all the books on our desk versus the Chamber viewer to find what we're looking for? I'm not saying we don't, but I'm not saying we have to. So in the cases you brought up, Senator Wallman, if it's illegal, it's already a problem and I think we have other ways to address that. And nothing we should do should advance that. But we shouldn't throw a herring in the way to say, we can't do anything anymore because of the actions of the individuals. [LB574]

SENATOR WALLMAN: Thank you, Senator Price. [LB574]

SENATOR PRICE: Thank you. [LB574]

SENATOR CAMPBELL: Any other questions? Senator Price, will you be staying to close? [LB574]

SENATOR PRICE: Oh, absolutely. [LB574]

SENATOR CAMPBELL: Good. [LB574]

SENATOR PRICE: Appreciate the opportunity. [LB574]

SENATOR CAMPBELL: You're always welcome to stay the entire time. How many in the audience would like to provide testimony in favor of the bill? Okay. Two? How many would like to provide testimony in opposition? Okay. And in a neutral position? No neutral. Okay. With that, we'll start with the proponents for the bill, those who are in favor. Good afternoon. [LB574]

JEAN PHELAN: (Exhibit 8) Good afternoon, Senator Campbell and members of the Health and Human Services Committee. My name is Jean Phelan, J-e-a-n P-h-e-l-a-n, and I am a registered nurse who resides in District 45. I am here today representing not only myself, but the Nebraska Nurses Association. The Nebraska Nurses Association is voice for approximately 30,000 registered nurses in Nebraska and we are asking you to support LB574. Electronic prescription information is supported by the Academy of Managed Care Pharmacy, dependent on reasonable and reliable assurances of authenticity, accountability, accuracy, and confidentiality. The Nebraska Nurses Association is in agreement with AMCP and we also support national standards that promote interoperability. There are many problems associated with traditional written and oral prescription orders, including errors of omission and commission, simple mistakes, and the possibility of fraud. Oral and written prescriptions can cause harm to patients, delay appropriate therapy, and processing of claims, waste patients' time, and increase unnecessary costs to the healthcare system. Electronic transmission offers advantages over oral and written prescriptions, including but not limited to reduction in errors such as illegible handwriting; save time for patients, healthcare providers, and pharmacists; enhanced initiation of therapy; and facilitated refill approval/denial process. Electronic prescription transmission promotes the potential for allowing drug therapy information to be stored online, making it readily available to patients' authorized healthcare providers. Some barriers to electronic prescription transmission exist, including limitations on controlled substances, reluctance by some healthcare providers to embrace the technology, confusion about standards, and lack of adequate user training. However, these barriers aren't sufficient to warrant prevention of electronic prescription transmission. The advantages outweigh the disadvantages. Advancing technology has promoted other healthcare system changes. Electronic prescription transmission has the potential to facilitate quality patient care and ease of use by healthcare providers. As a healthcare consumer, I would directly benefit from this legislation. Currently, my nurse practitioner must either fax or phone in prescriptions for me. I have frequently encountered problems with fax breakdowns or a back-load of phone messages at the pharmacy, preventing timely filling of my prescriptions. Often, I have been forced to call my doctor's office to have the prescriptions faxed or phoned in again. This has resulted in confusion and delays in getting my prescriptions filled. If my nurse practitioner could directly send my prescriptions electronically, these problems wouldn't occur. So we ask that you support LB574. [LB574]

SENATOR CAMPBELL: Questions from the senators? Thank you very much for your testimony today. Other proponents? Good afternoon. [LB574]

PAUL PLOFCHAN: (Exhibits 9-11) Good afternoon, Senator Campbell. My name is Paul Plofchan, and that's spelled P-a-u-l, the last name is spelled like P, Peter, l-o-f, as in Frank, c-h-a-n, like Nancy. And I'm coming before you today on behalf of Pfizer Pharmaceutical's for whom I'm a registered lobbyist, where I'm the director of

government relations for the state of Nebraska as well as the states of South Dakota, North Dakota, Wyoming, and Montana. Also in terms of transparency, although I'm here on behalf of Pfizer, some of my associated involvement includes, I'm on the board of directors for Bio Nebraska, the state's life sciences association. I just recently came off the board of Arthritis Foundation of Nebraska where I chaired the public policy committee, at the end of 2010, and I also just recently joined at the end of 2010 the state's working group on eRx. But I'm here today as a registered lobbyist for Pfizer and representing Pfizer. I prepared testimony of which I'm not going to read it word for word. I would move some highlights and then we can move to question and answers. So Pfizer is the world's largest pharmaceutical company. We have a profound interest in advancing e-prescribing as it aligns with our mission to advance quality and safety of healthcare. I commend the panel and also Senator Price for bringing the issue before this committee, and I thank Senator Price for his remarks asking us to focus not on technical policy standards, but to focus rather on state level policy that, as he described, protects the patient, protects the patient-physician relationship and advances e-prescribing. So thank you, Senator Price. Widespread adoption of eRx is important. It's underway and it's being accelerated by federal incentives. ERx helps reduce medication errors such as reducing illegible handwriting. It serves to benefit physicians. It serves to benefit patients and it serves to benefit pharmacists because it automates decisions to put support tools such as medication lists, what product formularies there may be available, and it can also be used to address formulary coverage, prior authorization, etcetera. As I mentioned, it's being accelerated by some important steps taken by the 2009 Federal High Tech Act, which has provided significant funding to physicians to acquire electronic health record systems which, of course, will have e-prescribing components to them. And also the bonus structure under meaningful use or the incentive dollars that doctors can get, gives...provides incentives to reach certain outcomes and those include e-prescribing outcomes. So good things are happening, so for the first testifier, good things are happening. And also, though, states are being encouraged to take on and to direct their own policies. National organizations such as the National Governor's Association, which has a center for best practices, has a position piece on e-prescribing encouraging states to get involved. Many other state legislators have acted. For example, in 2010 strong eRx provisions began in over ten states and currently there are at least 16 states looking at eRx legislation. So Pfizer supports LB574 because it addresses several core principles. I want to touch base on those and discuss them in terms of three core tenets. They are: put the patient first; support the clinical judgment of professionals so that they can make the best outcome or choose the best treatments for their patients without undue influence; and also ensure integrity of the information that's used in that clinical decision-making. LB574 asks for certain things. It says the provisions allows for a prescription drug order to be transmitted without interference by a third party directly to, from the doctor to the pharmacists. That mirrors what goes on in the paper process. Right now, when you're consulting with your doctor and they pull out their prescription pad they get a blank pad, they write a legally allowable prescription based on their decisions about what's best for

you in consultation with you, you take that to Walgreens. One of the principles is you should be able to do that electronically too, without interference. There's a provision also asking for electronic prior authorization process, one that's consistent with technologies that are being developed by the National Council for Prescription Drug Programs or NCPDP. This is asking for the use of technology that's either already been piloted or is waiting to be piloted to have industry embrace that and move it forward. This accredited or standards development organization has been working on this since 2005 to develop these standards to bring electronic prior authorization. And as you know, from your own...I heard Senator Price talking about some widget you all have, so you're technically savvy folks. You know that...six years in terms of technology is a life year. We should be doing an awful lot. And finally, it requests that there be an advisory committee formed with the Department of Health to establish prior authorization standards. Put the patient first, appropriately design e-prescribing tools that allow the doctor to remain in control. There's sections on alerts and pop-ups so that nobody enters the room when you're talking to your patient electronically via an electronic system. You have to knock first, if you will. It's between the doctor and the patient. Finally, it also asks to support better clinical decision-making by allowing the doctor to have the formulary data available, specific clinical copay data available, and to then be able to address those pop-ups and just like you at home have the ability to regulate what comes into your home computer, so does the doctor. Nebraska has an important role to play. States are getting involved. I shared with you as a handout, for example, language, specific language from states that addressed the alerts in messaging. This is best practice legislation and the verbiage that Senator Price has used is closely aligned with that. And with that, I think I'd like to open it up to take some questions. [LB574]

SENATOR CAMPBELL: Questions from the senators? Senator Gloor. [LB574]

SENATOR GLOOR: Thank you, Chairman Campbell. Paul, help me try to understand something, that is, with what the federal government is trying to do with information technology and an expectation that at some point in time they will become perhaps the driver in all this, why is this necessary if the federal government seems to have us moving inexorably towards whatever they design, which I'm guessing will trump whatever we do? [LB574]

PAUL PLOFCHAN: I think that's a terrific question, Senator Gloor. And so Senator Campbell, Senator Gloor, I would answer that by saying, I don't believe it's the federal government's intent to be controlling what we do. I think that what...and I referred to I believe what your talking about, and correct me if I'm wrong, the federal government has provided incentives recently, in 2010, significant incentives. Approximately about $44,000 to a primary care doctor over a series of years to accomplish health information technology goals, including e-prescribing. But even in the HITECH document, the final rules that they published last summer, they say that these standards and certification processes tend to be...are designed to be the floor, not the ceiling. And they leave a lot

of autonomy. The...it's important, though, I think, that the federal government got behind it and is helping to advance it. And I applaud that. When you go to some of the issues though that we're talking about here, those are not those same technical standards. We're talking about policy standards, about how you'd like your e-prescribing system to look in your state. For example, with the language I shared with you on e-prescribing alerts and messaging, without state protections, there are no protections. The federal government doesn't have any of those protections to talk about addressing the type of pop-up. For example, what does it protect a patient against? It protects the patient from influence from a company like mine. That language would prevent our company from contracting with an EHR vendor to allow us to market when the doctor, you know, if we're tracking via cookies and they were to write a competitive product, we can't enter the system and say, would you like to choose one of ours. The same is true, though, it also says the payers that...you know, that language says you can't give a pop-up if a doctor selects product A, you can't pop him up during that meeting and say, you sure you don't want to change to this, when the doctor has already been considering those options. And that doesn't just work in a branded scenario. I've given you an example in my testimony, but one you might...you know, everybody here might identify with is quite simple and we just use two generic antibiotics. Doctors might be...write a product called azithromycin, which is a product that has a once a day dosing regimen and though it has a side effect profile, the side effect profile isn't the same as a product called azithromycin. You may have taken...I mean, excuse me, amoxicillen. You may have given your kids amoxicillen. But it's a four-time a day product. You're going to take a dose for maybe ten days, twelve days. It also has a high GI issue, you know. So the doctor might say the kid's in school, I'm going to give you this generic. It's a once a day dose and you take it before you go to school and you won't be running out from the classroom to go to the bathroom, so you'll have a whole day in the class. Somebody could prompt, though, without these protections because it's more expensive than the even older generic. You could get a prompt that says, sure you don't want to take the four-time a day product? It's 15 percent cheaper. You know, even though the doctors are...it's a patient protection, so. I guess, to try to be concise, even though I haven't been, Senator Gloor, I would say that the federal government is not trying to address every issue. They say in their final rule that those guidelines are about certification of vendors and they leave plenty of room open to the state. And as one final example, I'd say that just yesterday the federal government sent out a press release sort of mentioning to several states, hey, thanks for getting involved. And one of the states, it's a direct program in Minnesota which has been very, very aggressive in their e-prescribing and e-prior auth. initiatives. They were praised by the federal government for being out there as a state and trying to drive e-prescribing. So hope I answered your question. It's a lot of information, so I hope I didn't overwhelm. [LB574]

SENATOR GLOOR: Thank you. I followed. [LB574]

SENATOR CAMPBELL: Other questions? One of the questions...I mean, we now

exchange information between pharmacies. For instance, if I'm in Arizona but I have a prescription in my home pharmacy, can I go to a pharmacy and have them dial up my pharmacy in Lincoln and say, I've lost my prescription and I'd like to get it? Will they e-...will they send it to that pharmacy? [LB574]

PAUL PLOFCHAN: Not knowing the particular systems and how they interrelate, I would want to ask, but I would answer with the affirmative that e-prescribing is a technology that's here with us and working. What this legislation tries to do is put some rules and patient protections around that, and then take the success of what you're talking about, where you're out of town, you can get your prescription sent to you, and address that to a program called prior authorization. So this LB574 is supportive of e-prescribing, and it also tries to make prior authorization, which is currently a paper process, make that an electronic process. And I believe what Senator Price was referring to there is, there's some questions out there. There's the argument going on right now whether or not the industry has the ability to do electronic prior authorization versus a paper process. I submit to you that they have the ability. The pilots have been running since 2005, and even on...of the e-prescribing pilots, to be clear, since 2005. And some of those pilots contained components for e-prior authorization. The initial results were an unwieldy process that wasn't quite so good. They got to go back to the drawing board but there's an NCPDP, the standardization organization I referred to, they had an e-prior auth working group that was put together. That working group has some additional standard products to be piloted that are waiting to be tested, but industry is not testing it. And that's one of the goals of LB574 is to get those tested. On that note, I also passed out to you the statute from Minnesota. Minnesota's approach to this as they waited for the industry to test the standard, which isn't happening, they said, okay, we're going to give you a deadline. And they said, you're going to have to test the standard no later than 2015. Now I test the standards, you got to approve the system. You'll notice that Senator Price in LB574, I think, has similar thinking where he has an implementation date of 2012. I think that's purposeful also, though, on Senator Gloor's question is to allow time for some of the other e-prescribing meaningful use stuff to work it's way through, which has 2011 targets. You know, there's an awful lot of targets under healthcare reform so you got to draw a calendar with some of these, but there's a purpose for those implementation dates, so. Yes, I think that in your case that would work just fine provided you didn't need a prior authorization, Senator Campbell. [LB574]

SENATOR CAMPBELL: Got it. [LB574]

PAUL PLOFCHAN: If you needed a prior authorization, you might be waiting at the window either several hours or maybe a day or two. [LB574]

SENATOR CAMPBELL: A long time. Any other questions? Thank you for your testimony. [LB574]

PAUL PLOFCHAN: Thank you very much. [LB574]

SENATOR CAMPBELL: Others who wish to testify in favor of LB574? Those who wish to testify in opposition? Opposition testimony? And we're going to want you to give your... [LB574]

DAVID ROOT: Yes. Yes, ma-am. [LB574]

SENATOR CAMPBELL: Otherwise I get in trouble with the clerk. [LB574]

DAVID ROOT: Oh, we wouldn't want that to happen. [LB574]

SENATOR CAMPBELL: Not on a Friday. [LB574]

DAVID ROOT: Not on a Friday. Not anytime. [LB574]

SENATOR CAMPBELL: Good afternoon. [LB574]

DAVID ROOT: Good afternoon, Madam Chair and members of the committee. My name is David Root. I represent Medco Health Solutions. We are a PBM or a pharmacy benefit manager that operate in the state. We currently administer the benefits for approximately 27 percent of the state of Nebraska. Very briefly, the role of the PBM is to help plan sponsors, such as governments, labor unions, large corporations, and small companies, administer and manage their drug spend for the drug component of their plan. I'd like to talk to you a little bit today about LB574. We've heard a couple of things and we've heard a couple of questions that were directed to it. It's very important that we understand exactly what we have here, and what we have can only be described as a wolf in sheep's clothing. Right now, several national groups, which we heard of shortly before that, CMS and the NCPDP or the National Council for Prescription Drug Programs, have been working on developing national standards for e-prescribing. The idea behind the national standards program would be to have one unified platform by which e-prescribing would take place in all 50 states. If Nebraska were to pursue LB574, initially what it would at it's least impact would require providers in this state to have to operate two additional platforms. One platform for Nebraska and another platform for any, say, Med D patients that they may take that would operate on the national standard. In addition to that, we've also heard how the intent of the bill was to look at the word...look at the platform as opposed to getting involved in the policies. One of the things that we've heard, specifically to the language addressing what you heard, was the idea of interdicting at the time that the prescriber is actually writing the prescription. The entire point behind e-prescribing is to allow the prescriber at the point of prescribing to have quality understanding of the patient's formulary, that being those drugs that that patient's plan will pay for, those drugs that that patient's plan will not pay for or will require some additional copay on behalf of the patient, or a drug that's on the

formulary that may require a prior authorization. Right now, under this legislation, that interdiction would not be allowed. We would not be able to assist the doctor in complying with the plan's formulary. Additionally, in that interdiction, that section that covers interdiction, also would not allow us to interdict at the point where the prescriber would be prescribing the patient the drugs, would not allow us to say to them, excuse me, but there's a generic version of this drug available that is significantly cheaper for the patient. The doctor may not be aware of the new generic that's available. That chilling impact on generic substitution opportunities would have a devastating effect on the payer, the person who's paying for the insurance policy, the employer, or labor union, or government, as well as its financial impact on the patient because they would have to then address the brand copay issue. However, it would have a significant positive impact on a brand manufacturer, on a brand manufacturer drug company's bottom line. Another issue in the maintenance of the formulary, that we help plans with the maintenance of their formulary is the idea of allowing a patient to go to any pharmacy that they so choose. We are asked on behalf of the plan sponsors to create pharmacy networks. So why...those pharmacy networks are pharmacies that have agreed to a discounted rate to service those patients. Why then would you want to be forced to publish a more...a pharmacy that is not in the network which would then require an enhanced payment on behalf of the plan and the patient? Additionally, there are some plans in Nebraska, as well as across the country, that will require maintenance drugs as a first-fill or second-fill, perhaps, to be filled at a mail order pharmacy in order to reduce the rate of copay and reduce the expense to the plan. The language in this bill would prohibit those such adherences to that plan. We would not be able to inform the doctor of the plan's wishes. With respect to prior authorization, very quickly, the issue behind prior authorization is very complex. NCPDP and CMS and other groups have worked tirelessly on trying to address this issue. It has been an ongoing issue for the last three to five years. There are pilot programs that are being...that have been developed and have been tested. They're evaluating that data now. Again, this is to roll out a national model, not to have 50 different independent platforms operating in 50 different states. The concern...the difficulty with prior authorization is the fact that even within a plan, a particular drug for one plan level may not be...may not require a prior authorization, but at a different plan level that drug may require a prior authorization. Prior authorization is a medical process by which we help the plan adhere to their formulary compliance. The language in this bill also requires us to provide the doctor with the answers to the questions for prior authorization prior to them asking us...asking the plan for permission for the prior authorization. So that's akin to, if you're a school teacher or you know any school teachers, that's akin to giving the kids the answers before you give them the test, effectively eliminating prior authorization. [LB574]

SENATOR CAMPBELL: Sir, we probably ought go to questions... [LB574]

DAVID ROOT: Yes, ma'am. [LB574]

SENATOR CAMPBELL: ...so we have time. Are there any questions? Senator Bloomfield. [LB574]

SENATOR BLOOMFIELD: Thank you, Senator Campbell. Dave, you said the doctor may not be aware of a generic that is...just newly become available. Would not the pharmacist be aware of that? The odds of neither of them being aware of that... [LB574]

DAVID ROOT: Well, the pharmacist, the idea would be that the pharmacist is aware of that, but what this bill is addressing is at the point where the doctor is typing in the prescription through the e-prescribing process. We would then be able through some sort of electronic medium, using the vernacular, perhaps a pop-up or a bubble or something like that, would be able to indicate to the doctor that there is a generic available, and to please make a medical decision right then and there as to whether or not their patient can use the generic. And as we've discussed, in this state, and in other instances in other committees, that is a medical decision as well as a personal decision that the doctor...a conversation that the doctor has to have with the patient. The patient may not be able to afford the brand name drug if it's not covered on the formulary, so the generic is the best opportunity, providing it's medically suitable for them. And the doctor can walk the patient through that decision process. [LB574]

SENATOR BLOOMFIELD: Anytime I've been prescribed anything, and the doctor has prescribed the name brand, my pharmacist has told me if there's a generic, and if I've had question with it, he's called the doctor back and asked if he could use the generic. [LB574]

DAVID ROOT: That's correct. That's correct. That's normally the way the process works. [LB574]

SENATOR BLOOMFIELD: I don't see the doctor not necessarily knowing that the... [LB574]

DAVID ROOT: There's often cases where the doctors are unfamiliar with, perhaps, new generics. That's not unusual at all. And I think, we...you know, there will be people behind me that you can address...that will address that even further. [LB574]

SENATOR CAMPBELL: Any other questions? Thank you, Mr. Root. [LB574]

DAVID ROOT: Thank you. [LB574]

SENATOR CAMPBELL: The next testifier in opposition. [LB574]

CLINT WILLIAMS: Good afternoon, Madam Chairman and members of the Health and

Human Services Committee. I'm sorry, I've got a little tickle in my throat. If I lose my voice halfway through, I'll try to work through it. My name is Clint Williams, spelled C-l-i-n-t W-i-l-l-i-a-m-s. I'm the director of pharmacy for Blue Cross Blue Shield Nebraska. Blue Cross Blue Shield Nebraska insures over 700,000 Nebraskans. While Blue Cross Blue Shield Nebraska strongly supports the concept of electronic prescribing, we feel LB574, as the language is written, goes beyond the scope of electronic prescribing by attempting to circumvent benefits designed to provide incentives for patients and providers to use cost-effective medications. LB574 prohibits a physician through electronic means from having information that would inform the physician of the availability of more cost-effective generic and formulary brand options. While these drugs are appropriate for patients for their conditions, these drugs will also lower costs for patients and health plans while keeping premiums from increasing like we've seen in recent years. The bill also requires a real time prior authorization process that is not currently available. There's been a lot of mention of pilot programs where the standards are being developed, but it's currently not available. Prior authorization is used to ensure safe, appropriate and cost-effective medications for patients' conditions. Overall, prior authorization affects a small number of our members and customers. LB574 provides that pop-ups, instant messaging, and advertisements cannot be used in transmission of a prescription. Currently, physicians who utilize prescriptions see a screen that provides the possible medications for a patient's prescriptions, and a pop-up or other notice from a program which contains formulary information or generic information that's supplied by the health plan. This is usually delivered through a pharmacy benefit manager as was described earlier. The notice and pop-up notifies the physician that a generic or formulary brand in the class of medication is available and it will be at lower cost, as I mentioned before. It's important to note that the physician will ultimately decide which medication is appropriate for their patient. However, the physician should have the ability to choose between generic formulary and nonformulary brand drugs. In today's world, a physician must deal with multiple formularies from multiple health plans or pharmacy benefit managers. For example, if a doctor wants to treat high cholesterol today, he has multiple choices for both brands and generics depending on the patient's bad cholesterol level. The shared goal of the health plan and the physician is to choose the best clinical drug for the patient's condition. Since there are a number of choices, we encourage the use of a product that will work effectively and be available to their patients at the lowest possible cost. In this world today, the physician has to know the difference between the various formularies. For example, a physician may chose Crestor because they have free samples or advertise that drug earlier in the day or earlier in the week without knowing the health plan has equivalent drugs or potentially equivalent drugs such as Lipitor or a generic drug called Simvastatin. These drugs are at a lower cost and they save the patients money and they help the physician provide not only just the clinical side, but also the financial side for a patient. Once this occurs, then the physician may be subject to calls from pharmacies or patients after the patient has left the prescribers office and they're calling back to ask to switch to a formulary brand drug or a generic drug because they want

something with a lower out of cost. Perhaps they have talked to their pharmacist or somebody else about their condition. Having these messages through e-prescribing allows them to have that information before they ever send that prescription, which should reduce the number of calls and avoid a lot of the calls that occur today. Therefore, when the patient is prescribed the drug initially, the electronic prescription, we give them the drug that is used to treat their condition, and also helps with their overall cost. I also wanted to note, the HITECH Act was mentioned earlier. Formulary checks are part of some of the optional choices for a meaningful use, which is required in order to get some of the funding that was mentioned earlier. I also want to talk a little bit more about generic drugs. We had a generic...free generic campaign a couple of years ago and we were able to increase our generic use quite substantially by offering free generics. And that was really the only way we could accommodate the sample process that we see today for brand drugs. Today our average 30-day total cost for a brand name drug is about $160, whereas a generic is just under $20. Through the first three quarters of 2010 we saw an 11 percent increase in the cost of brand name drugs. We saw an 8.4 percent increase in generics. That still kept the drugs under $20. We've seen similar increases to brand name drugs over the last few years. We haven't always seen increases with generic drugs. As a matter of fact, we saw a couple years where we saw a negative increase in the average cost of drugs likely due to increased competition and $4 generics at Walmart and some of the other places. I know a lot of other discussion has gone on about prior authorization. Prior authorization, I mentioned, is a for a small number of our members but it is very important. We use this for certain drugs that pose a safety risk, have a high potential for off label use, or prescribing doses exceeding normal doses. Cost is also a consideration. Upsetting this balance will fundamentally alter the nature of a benefit plan by essentially mandating coverage without regard to safety and cost factors. A lot of discussion about the pilot programs with NCPDP and there's another entity called Surescripts that has been a key part of electronic prescribing. And we believe that those entities have done a very good job of helping develop the standards and should be continued to allow to do so. To have a separate set of standards in Nebraska, that has been discussed earlier and we agree that that would cause some issues. We also believe that there's a lot of innovation that can occur when the standards are the same across the country as opposed to having standards in Nebraska, Minnesota, and other states. And, therefore, we feel it's preferred that it's done there as opposed to someplace like HHS. [LB574]

SENATOR CAMPBELL: Mr. Williams, we probably need to finish up for any questions here. [LB574]

CLINT WILLIAMS: Absolutely, Senator. [LB574]

SENATOR CAMPBELL: Okay. Questions from the senators that you'd like to ask? Thank you, Mr. Williams. [LB574]

CLINT WILLIAMS: Thank you. [LB574]

SENATOR CAMPBELL: The next testifier in opposition. Good afternoon. [LB574]

JONI COVER: (Exhibit 12) Good afternoon. Senator Campbell, members of the committee, my name is Joni Cover. It's J-o-n-i C-o-v, as in Victor, e-r. I'm the executive vice president of the Nebraska Pharmacists Association, and on behalf of the members of the Nebraska Pharmacists Association I appear today in opposition of LB574. Electronic prescribing is currently allowed in Nebraska, with the exception of controlled substances, which is not permitted by the DEA. According to statistics provided by Surescripts, 78 percent of the pharmacies in Nebraska can accept electronic prescriptions, while only 11 percent of physicians are engaged in e-prescribing. For pharmacy, the downside of e-prescribing is the cost because we have to pay for it through our transaction costs and the new errors being generated. Every prescription transaction, and every transmission to resubmit an e-prescription that was erroneous, costs the pharmacy both in money and in pharmacist's time. In the retail pharmacist's perfect world, and, you know, we'd like to get there, all prior authorizations, all formulary decisions, all copay determinations, and all third-party rules would be dealt with before the patient ever got to the pharmacy. So once we had the prescription we could fill it and send the patient on their way. And maybe that is what LB574 is trying to achieve, but the bill is inadequate in many aspects of the e-prescribing process. The language that is stricken in Section 6 of LB574, and replaced by the word "e-mail" is extremely problematic and actually sets electronic prescribing back in Nebraska. Electronic transmission is a term that encompasses the various ways that a prescription can be sent to a pharmacy. By limiting the transmission to e-mail only, pharmacy workload will increase tremendously. In addition, and there's been some discussion about NCPDP standards, I don't believe that there is a current standard, a current platform, or a platform that reaches all areas of e-prescribing to deal with formulary and prior authorization. And I'm certainly not an expert in that area so I could be wrong, but I don't believe that there is something that is standard across all e-prescribing programs. In the attempt by LB574 to limit the messaging that appears on a prescriber's e-prescribing software, and because of the broad meaning, patient safety, in our opinion, is an issue and may actually increase harm to patients. The messages, not advertising, are a part of a prescriber and pharmacy software to alert providers of drug-drug interactions, inappropriate dosages, allergies, generic alternatives that may be less expensive to the patient, and other such alerts. Messages such as these are vital to the safe dispensing of medications. LB574 mandates that a prescriber can prescribe any medication that he or she feels is necessary for the patient without any interference or limitations by a third party. And I question whether or not pharmacy is considered a third party because that would then prohibit us or greatly limit our ability to do generic substitution. The bill, however, does not address who pays for the medication, especially the brand name meds. If an insurance company won't pay for the medication that's chosen by the prescriber, so basically we're telling the prescriber he or she can prescribe anything that

he or she wants to, and there's no substitution allowed, which we're not clear is addressed in the bill, then the assumption that the patient will have to pay cash or they won't get their medication, and that certainly does not result in good patient care. I will say that the NPA is willing to continue our discussion with the committee and with interested parties on e-prescribing. E-prescribing is here and when it works, great; it's a fabulous thing, but I will tell you that the perfect system of e-prescribing does not exist today and I have lots of pharmacists who would be happy to share their experiences with e-prescribing with you. So I would urge the committee to indefinitely postpone LB574, and I thank you for the opportunity to comment today. [LB574]

SENATOR CAMPBELL: Questions for Ms. Cover? Thank you very much. [LB574]

JONI COVER: Thank you. [LB574]

SENATOR CAMPBELL: Others wishing to testify in opposition? Good afternoon. [LB574]

DOUG JOHNSON: (Exhibit 13) Good afternoon, Madam Chairman. As the other gentleman mentioned, my throat is a little scratchy coming down from Minnesota. I'm used to the cold weather, but...(Laughter) [LB574]

SENATOR CAMPBELL: Do you need a glass of water, sir? [LB574]

DOUG JOHNSON: No, I'm fine. [LB574]

SENATOR HOWARD: Or a generic cough drop? (Laughter) [LB574]

SENATOR CAMPBELL: Senator Howard's on the game this afternoon. (Laughter) [LB574]

DOUG JOHNSON: Very good. Very good. Well, Madam Chairman and members of the committee, my name is Doug Johnson. And my company has been mentioned a couple times. I'm here representing Surescripts. I'm before the committee as a business manager, not as a lobbyist, not as a professional lobbyist. I've been in IT for the last 25 years, focused on healthcare IT for the last nine years with Surescripts. So I feel qualified to address the committee regarding LB574. And much of my commentary will be focused on the technical aspects of the bill. Previous testimony, I don't want to go back and revisit that. I think it was well stated. I think other opposing points of view are supported by Surescripts as well, and rather than waste the committee's time rehashing what's already been talked about, let's dig in here. So just as reference, we do operate--when I say we, Surescripts operates--the nation's largest health information technology network. We do support the most comprehensive infrastructure of healthcare organizations nationwide. Pharmacies, physicians, payers, pharmacy benefit

managers, hospitals, health information exchanges, health technology firms all rely on Surescripts to more easily and securely share health information. As a matter of fact, the vast majority of electronic prescription messages transmitting in the United States today flow through our network, and there are currently 1,400 prescribers and 361 pharmacies in the state of Nebraska actively using our network to exchange such messages. So we've heard testimony that e-prescribing is alive and well and growing. It is. It is nationally and it is certainly here in Nebraska. You know, given our central role in the electronic transmission of prescription-related information, obviously we are keenly interested in some of the requirements. In general, we have strong concerns about the specific technical requirements made by this bill and are opposed to the bill as drafted. You know, and if you think about that, that might be a little unusual for an organization like ours, who are all about adoption of e-prescribing, it's our founding business principal. We do agree with many of the intended outcomes of the bill. However, do not believe in its current state it is in the best interest of the state of Nebraska prescribers and pharmacies or the health plans. So in addition to it not being needed, the specific requirements that have been addressed around prescription benefits and prior auth process are real concerns. The standards that have been referenced through NCPDP that have been endorsed by CMS, Surescripts has played a central role along with other key stakeholders from pharmacies, from the health plans, from the payers, from the health information technology vendors in creating those standards to the point that CMS has blessed a number of those around real time eligibility, request for response, formulary benefit, file transfers, medication history profiles, new prescriptions, refilled renewal prescriptions, all actively exchanged through our network. I think there were some stats about, you know, financial transactions. You know, we're so used to these numbers, billions and billions. Well, you know, today a lot of people don't realize, there are billions of electronic prescription messages flowing annually in the United States. There are over 225,000 physicians actively prescribing on our network. There are over 50,000 pharmacies nationwide actively connected to our network and accepting messages. There are health plans representing 240,000,000 Americans connected to our network to share benefit information to prescribers at the point of care to help with the decision support process around e-prescribing. Now it is important to make clear that we do agree that with physicians, pharmacies, payers, that an electronic prior authorization process would be desirable and beneficial. To that extent we've been engaged in the pilots that have been referenced. Those pilots are exactly what a pilot is supposed to be, testing standards, seeing where the market is, is there appropriate time to adopt technology. And in all cases, in both cases I should say, there were two. One was a 2006 pilot that we were funded through the centers for Medicaid, Medicare services. CMS determined, based upon those results, it was not, the prior authorization was not ready to be endorsed as a standard for e-prescribing under CMS. The second pilot in 2009, a very small pilot, was not so much targeted to find the standard but defining market acceptance. Did the physicians like electronic prior auth? And while reception was good, they also recognized that until a national standard existed it would be very difficult to see broad acceptance. This concept of a 50 state patchwork is real.

The idea that the national health information technology infrastructure is growing and is being built is important concept in driving nationwide adoption in interoperability, which is a key component going forward. I see my light is red. You know, there are specific points and I'm glad the last person testified and pointed out that in Section 6 this change from electronic transmission to e-mail is significant. It is problematic. It's akin to saying the ATM trans, the financial transactions that you send are being sent e-mail. Well, they're not. They're sent via a data standard that is a system, the system exchange of information. [LB574]

SENATOR CAMPBELL: Thank you. Mr. Johnson. Are there questions from the senators? And thank you for providing it written. We'll at least have all of the points here. [LB574]

DOUG JOHNSON: Yes, absolutely. Thank you. [LB574]

SENATOR CAMPBELL: Thank you. Next testifier in opposition. Are there others in the room who wish to testify in opposition? Mr. Buntain is the last. [LB574]

DAVID BUNTAIN: And the shortest. Senator Campbell, members of the committee, I'm David Buntain, B-u-n-t-a-i-n. I'm the registered lobbyist and attorney for the Nebraska Medical Association and we are here today in opposition to LB574. We had our legislative commission meeting last night and had a spirited discussion about this bill, and many of the pros and cons were discussed, and the people who preceded me are much more expert about those. I think the general impression that we ended with was that this bill, while laudable and certainly everyone in the medical profession is...sees the value of e-prescribing, that it's a work in progress currently. There are concerns that have been expressed about national standards and so from our standpoint we don't think this bill is ready to go anywhere. We think the discussion should continue, and because of the impact it has on patients and on physicians, we would like to be involved in that discussion. [LB574]

SENATOR CAMPBELL: The clerk took you at your word and put you on both green and red. (Laughter) [LB574]

DAVID BUNTAIN: Excuse me? [LB574]

SENATOR CAMPBELL: The clerk took you at your word and put you on both green and red. (Laughter) [LB574]

DAVID BUNTAIN: I don't pay attention to the lights. (Laughter) [LB574]

SENATOR CAMPBELL: You can just tell it's Friday afternoon. We have a few gremlins here. Any questions for Mr. Buntain? Senator Howard, did you have a question?

[LB574]

SENATOR HOWARD: Well, no, thank you. [LB574]

SENATOR CAMPBELL: Okay. We'll check something. Thank you very much. [LB574]

DAVID BUNTAIN: Thank you. [LB574]

SENATOR CAMPBELL: Senator Price, would you like to close on... [LB574]

SENATOR PRICE: I would love to, if you don't mind. Thank you. I know it's a Friday and we have a lot to do yet today so I'll try to be brief. Senator Campbell and the committee what you heard today with passion, eloquence, and specificity, talks directly to the importance of the subject. We've heard about millions of people are doing this with the prescriptions. We've heard that many of our pharmacies are engaged in e-prescriptions here. It's kind of like, I guess, how people might have felt about e-mail 15 years ago. Text messaging five years ago, or Facebook last year. There are things that are coming down the pike that we have to deal with. I took some notes from the testifiers and the first thing I wanted to say was with all that emotion, and that shows how important it is that we all come to the table and work together, continue to work together. And that's what this is about. This is about coming to the table and finding the solutions, not defending fiefdoms. All right? Now, I didn't hear anybody here today saying they're trying to defend a kingdom. All right. I think most people came up today wanting to work together. But I did also find some other notes that were pretty interesting. And first and foremost, I want to thank the opposition that came today because they vetted out what their problems were and they found some really good ones. And we're going to work together. I don't expect that this bill is going to go forward nor would I recommend it does. But I would also recommend that we don't IPP it so people go away thinking it's gone, now we can go two more years. And I'll give you a reason why. When we heard the testifiers say, we have people from Minnesota (inaudible) Surescripts a fantastic company, doing the business now. So we have a private entity doing it in another state. We have states doing it. We have CMS doing it. The federal government. Everybody is playing but Nebraska. You're not invited. So the question is, do you want to be invited? Or do you want to sit back and say, hey, before you start us, that which you would like to do? I don't think that's a good place to be. Never found to be the place to be to be, you know, behind being forced on. And I'd like to address the part about the prior authorization which is a lot of what we're talking about here. And that is, how much paper are we generating? Is it 5 percent of the population that's getting prior authorization? We don't know. But if you use the numbers, and I ran a quick numbers and I won't hold them to it, but we could be looking at 150,000 pieces of paper a year or more or maybe a month that we're generating. All right? Now the automated process. You're sitting in the doctor's office. You already know your plan. None of you are unintelligent, can't figure out what your plan is in your network and you could have dealt

with your doctor for ten years. And you're sitting there and you pay your $60 and they're going to tell you, come back again, we'll tell you if you can have your drugs, your medication. We got to get authorized. And we go back to paper and faxes. Now the automation process, and that's what I want to focus on, the automation and the process. What are the rules we need to do to make sure it's good, let's do it. They brought up great points. The e-mail point. What a great point about Section 6. I absolutely agree. We're going to have to do work on that, but what we can't do and what we can't allow Nebraska to do is to be at the end of the decision chain. We don't have a university here for to sit around and twiddle their thumbs. We don't have the PKI here to do nothing. So we need to take advantage and harness that and put that on the table with everybody and work together to make sure we address all these concerns. So again, I would ask the committee that in your consideration that we leave it open and I will, with my staff and with yours, reach out to the parties that came today and say, let's sit down and find out where we can find common ground, move forward and be a part of the solution, instead of just sitting back and waiting to see what happens to us. And with that, I would close and answer any questions you might have of me. [LB574]

SENATOR CAMPBELL: (Exhibits 14-16) Thank you, Senator Price for your close and we want to note for the record that we received a letter from Prime Therapeutics in opposition and opposition from the Nebraska Hospital Association and a letter of support from the American Cancer Society. So thank you, Senator Price. [LB574]

SENATOR PRICE: I think Senator Bloomfield might have had a question. [LB574]

SENATOR CAMPBELL: Oh, I'm sorry. [LB574]

SENATOR BLOOMFIELD: Thanks fine. Thank you, Senator Campbell. Thank you, Senator Price. My question has to do with the widgets you were talking about and the paper books we have upstairs. [LB574]

SENATOR PRICE: Sure. Sure. Right. [LB574]

SENATOR BLOOMFIELD: You watch, I go to those paper books fairly regularly. I'm not a widget person. Unfortunately, my doctor is the same age I am. He's not a widget person. (Laughter) I'm afraid if he goes to the widget and tries to send something, he might send me Prozac instead of penicillin. (Laughter) Is somebody going to...is he going to relay the message to someone and they send it or is he going to send it? [LB574]

SENATOR PRICE: You know, I tell you, Senator Bloomfield you brought up a great point that we talked about in beginnings of this bill. That problem does happen. No one says because you typed it out it came out perfect. Spell check doesn't work for everything. Some of those chemical names, you know, medication can be quite taxing.

There would have to be a phase-in, there would have to be a lot of things done. There's no denying that aspect of it. But the...I'll tell you what, I went to a, Metro Omaha Medical Society has a program that people can follow around and I went and followed a tremendous doctor who did some wonderful surgery on a cochlear implant and what's amazing is, they had a tablet. And he went to his tablet and this tablet had all the premade forms that...the ones that they always go through. And he (snaps fingers, makes noise) to the forms, got it all done. Got everything done and then he can get back to a patient. He was able to capture that and get back. So there's a place between the paper and the tablet. And my question, what I'm trying to do is get us there as part of the solution. I don't think any of the other players want to exclude us, but there's obvious advantages to being part of the team that makes the decisions. So with that, I hope that answers your question. [LB574]

SENATOR CAMPBELL: Okay. Thank you, Senator Price. [LB574]

SENATOR PRICE: Thank you so much for enduring me on a Friday afternoon. [LB574]

SENATOR CAMPBELL: We will close the hearing on LB574 and open LB466, which was introduced by Senator Gloor on behalf of the Governor to change provisions relating to a preferred drug list under the Medicaid Prescription Drug Act. And presenting on behalf of the Governor is Senator Gloor. [LB466]

SENATOR GLOOR: Thank you, Senator Campbell, fellow members. LB466 changes...excuse me, my name is Mike Gloor, G-l-o-o-r. I do that as a reminder not just for me but for all the other people behind me, so it happens. LB466 changes provisions for the Nebraska Medicaid Preferred drug list, which I will refer to from here on out as the PDL, to include antidepressants, antipsychotics, and anticonvulsant therapeutic drug classes. These are currently exempted drug classes. They compose a significant number of overall prescriptions paid by Medicaid including these drugs, and the PDL would allow the state to negotiate supplemental rebates from drug manufacturers. Preferred drug list was set up originally by LB830, the Medicaid Prescription Drug Act, and your bill summary--and kudos to counsel--does a wonderful job kind of taking us back to the history behind how we currently came to LB466. But as a brief reminder, it was introduced by Senator Lathrop in 2008. The act requires the CEO of Department of Health and Human Services to negotiate discounts, rebates on prescription drugs purchased from drug manufacturers and labelers, and to establish the PDL. The drugs in question today were excluded from this original PDL. Currently, Nebraska Medicaid participates in the optimal PDL solution known as TOP$. It's a multistate purchasing pool that negotiates and collects supplemental rebates for 64 drug classes--not 64 drugs but 64 drug classes--which are reviewed annually by a pharmaceutical and therapeutic committee and the Department of Health and Human Services. The pharmaceutical and therapeutic PNT committee reviews and makes recommendations about drugs to be included in the PDL. And as a reminder, this committee includes at

least eight physicians, four pharmacists, a university professor of pharmacy or a person with a doctoral degree in pharmacology, and two public members. A prescription drug is included in the PDL if the prescription drug is therapeutically equivalent to or superior to a prescription drug on the list and the net cost of the new prescription drug is equal to or less than the net cost of a listed drug after consideration of applicable rebates or discounts negotiated by the department. Adding antidepressants, antipsychotic, and anticonvulsants to the PDL will provide appropriate pharmaceutical care to the Medicaid recipient in a cost-effective manner. The department will use the same review standards and appeal process that they currently use for the PDL, and I would emphasize that: The department will use the same review standards and appeal process they currently use for the existing PDL that's in place. Since there's some concern over how the appeal process works, and it was a big concern of mine, I asked the department to inform us today about how the appeal process works for drugs on the PDL and to tell us the experience up to this point. I've been assured by Director Chaumont that current Medicaid clientele will be able to remain on their current antipsychotic, anticonvulsant, or antidepressant medications. This was important to me. It was important to me for several reasons not the least of which is I had concerns of a large number of assistance applicants who currently were on these regimens having to be moved in one fell swoop over to new regimens if that, in fact, was going to be the case. My assumption is not all would, in fact, be moved, but for the process that requires appeals and whatnot to be worked through would seem to me to overwhelm the system. Obviously the department agreed, which is why currently those on those regimens will remain on those regimens. However, I'm working on an amendment that would assure current Medicaid clientele that if their current prescriptions of these drugs are working for them, they will not suddenly be forced to make that change. In other words, I will be bringing forward an amendment that makes it clear that I appreciate the department's comments that they have no interest in making that movement, but I will build it into the legislation. I know there will be opposition to this bill. As a healthcare administrator for several decades, I can tell you the changes in PDLs were almost always met with resistance. I am aware of the need for flexibility and discretion in using PDLs. My bill will not change the availability or the ability of clinicians to prescribe necessary medications outside the formulary. I believe the appeal process is sound, I believe it's controlled by pharmacists and physicians who know that one size does not fit all, but I also know that too many healthcare providers make their prescribing decisions based upon information provided in the marketing of drugs rather than in sound science and sound medical practice. We have a responsibility to be good stewards of limited resources. This bill attempts to fulfill that obligation. The projected savings on this would be $936,000 in General Funds each fiscal year, so for the biennium we're talking about just under $2 million. I ask for your support and I would be glad to answer any questions. [LB466]

SENATOR CAMPBELL: Senator Krist. [LB466]

SENATOR KRIST: This is straight to the fiscal note, Senator Gloor. If all the current

people that are on the expensive drugs as opposed to the more inexpensive drugs are going to be allowed to stay on the drug of choice or the drug of the doctor's choice or whatever is being used, how do we come to a fiscal note that says that there's going to be a savings? Wouldn't there be assumption that every person who is currently on the drug would stay on the drug? [LB466]

SENATOR GLOOR: I think there is a strong assumption that's the case, but I think that also tells you the scope to which these medications are prescribed across this state anyway and the fact that new recipients of these medications would, in fact, then fall under the PDL. I had seen original savings...I began looking at this two years ago when I first got down here when I found out that these were excluded from the PDL that had just been put in place, and the numbers that I was looking at or the savings at that point in time that were given to me by the department were triple or quadruple what we're looking at here. So this made sense to me because most recipients if not all the current recipients of these drug regimens will probably stay right where they're at unless their clinicians choose to change them. So a lower number made sense to me because it's far lower than what I saw originally might be the potential savings if everybody was moved. [LB466]

SENATOR KRIST: So do you have any idea or were they able to tell you what the total dollar amount was of the psychotropic and other drugs that were named? [LB466]

SENATOR GLOOR: No, and maybe somebody from the department that's here would have that number, but I don't know, Senator Krist. [LB466]

SENATOR KRIST: Okay. Thank you. Thank you, Chair. [LB466]

SENATOR CAMPBELL: Other questions? Senator Cook. [LB466]

SENATOR COOK: Thank you, Madam Chair. You made a statement that you would be certain to not have people moved off of their current drug protocol and that you would clarify that within the language of your bill proposal. [LB466]

SENATOR GLOOR: My amendment, yeah. [LB466]

SENATOR COOK: An amendment. I guess it kind of piggybacks on what Senator Krist asked in terms of how can you anticipate a number...a savings in terms of the number of brand new people who would come on and be prescribed the generic version of the psychotropic drugs versus the name brand version, for lack of a better way to describe them? [LB466]

SENATOR GLOOR: I think this goes back to the science and mystery of fiscal notes, and the fiscal notes that get pulled together are based upon information that was

provided by the department. And so my expectation would be that if you directed that question to representatives from the department, somebody might be able to give you the specifics. [LB466]

SENATOR COOK: All right. Thank you. [LB466]

SENATOR GLOOR: But my assumption has been that it shows you the extent to which this category of medications is highly prescribed in all populations, not just Medicaid. [LB466]

SENATOR CAMPBELL: Senator Howard and then Senator Bloomfield. [LB466]

SENATOR HOWARD: Thank you, Madam Chairman...Chairperson. When I worked at foster care, we had situations where a child was put in a less-restrictive--that's what the term was--less-restrictive environment that didn't meet his needs. We knew the child would fail. We knew if we took a violent, acting out, sexual...child who's identified as a sexual perpetrator and put them in a foster home, they were probably going to fail. And so they had to fail and then they could be moved into the next level until we finally figured out what might address their needs. It kind of strikes me the same way with this. We're going to put folks on a more of a, say, an older drug that's been used in the past whereas there may be more modern drugs that we have evidence that are more effective. Is that the way this is going to work? [LB466]

SENATOR GLOOR: Well, there will be testifiers after me who will say the system never works right, that the system always forces people into something that sets them up to fail. I can't imagine that the department, anymore than my healthcare institution, puts together a formulary with an expectation that this is going to have a bad outcome so that we'll be forced to deal with spending even more time and resources to finally get to a good outcome. I mean, we have clinicians involved in making these decisions. We have an appeal board made up of pharmacists and physicians who get involved in making these decisions. Can I guarantee there's not going to be trial and error? I'm not sure there...I certainly can't because I'm not a clinician and maybe some of the people who testify who are clinicians can tell you, yes, there's a fail-safe way that they could make sure that it's never a trial and error, but I don't know if that's possible. I don't think the system is set up. And I would remind the committee that we already have had this PDL in place for all other categories of treatment except for this particular grouping. And as best we can determine, the process that's been in place has been working and we haven't had failure of any number of other diagnosis and treatment regimens for the Medicaid patients. Is this a dicier category? Absolutely. I don't argue that point. That's the reason that, (1) I wanted to make sure and want the department to explain to us the appeals process, and (2) that we're not moving people who are currently under drug regimens off of those for a period of time, and that's the reason for my amendment. But I'm comfortable with the bill and I'm comfortable with the process. [LB466]

SENATOR HOWARD: Well, since you brought it up. The appeals process, isn't this a category of individuals that might not be able to enter into an appeal process very easily? Who would handle that? Is that the physician or is it the patient? [LB466]

SENATOR GLOOR: Oh, I think it's almost always the clinician. [LB466]

SENATOR HOWARD: So we'll be expecting them to give us their time to do that as well when it's necessary? [LB466]

SENATOR GLOOR: Well, I have to be careful not to lean too heavily on my background, but usually when I dealt in my institution with appeals to PDL, it was usually a clinician-to-clinician discussion. I say clinician-to-clinician, you know, any category of person involved in providing patient care. I think the first step in an appeal goes to a technician not a pharmacist, but after that I know that, the next level up if there's a disagreement, it's to a clinician, so. [LB466]

SENATOR HOWARD: Okay. Thank you. [LB466]

SENATOR GLOOR: Yeah. It's a good question. [LB466]

SENATOR CAMPBELL: Senator Bloomfield. [LB466]

SENATOR BLOOMFIELD: Senator Gloor, this might be a question I want to save until your closing, but I would like to do just what you said you wouldn't want to rely too heavily on (laugh) and have you share some of your history and background on dealing with this. I guess I'll let you decide if you would rather do it now or you think when we're done. [LB466]

SENATOR GLOOR: I think in the interest of time...thank you for that and assuming that the Chair will provide that degree of flexibility, there may or may not be a reason for me to have to lean back on that. And so if it's possible if there's such a thing as a "gimme," I'll...or I guess it's a...what's the term in golf? [LB466]

SENATOR KRIST: Mulligan. [LB466]

SENATOR GLOOR: Thank you. (Laughter) And I play golf. That tells you I never take mulligans if I can't think of the term. If I could ask for a mulligan, I might use it, so. [LB466]

SENATOR BLOOMFIELD: Let's put it more simply: I'll ask the question later. [LB466]

SENATOR GLOOR: Okay. That's great. [LB466]

SENATOR CAMPBELL: Okay. Thank you very much. I just want to remind those folks in the audience that this is a continuing part of the committee's look at the budget bills statutorily that we'd need to comply with the Governor's budget and that the budget that the Appropriations Committee is looking at. And I appreciate Senator Gloor willing to introduce that on the part of the Governor. With that, how many people in the audience wish to testify in favor? Okay. I got that one. And how many people wish to testify in opposition? One, two, three, four, five, six, seven, eight, nine, ten. Okay. And I'll remind the ten people, please do not repeat yourselves if at all possible. Try to present new information. That's a lot of opposition. Those people who wish to testify in a neutral position? Okay. We will take the testifier in favor of LB466. [LB466]

KERRY WINTERER: (Exhibit 17) Good afternoon. Senator Campbell, members of the Health and Human Services Committee, my name is Kerry Winterer, that's spelled K-e-r-r-y, last name is W-i-n-t-e-r-e-r. I am the CEO of the Department of Health and Human Services. I am here to testify in support of LB466. I would, first of all, like to thank Senator Gloor for introducing this bill on behalf of the Governor. The enactment of LB466 is essential to adoption of the Governor's budget which assumes a savings generated by this bill. This bill will expand the existing preferred drug list by eliminating the exclusion of three classes of drugs in statute. Under this bill, the Department of Health and Human Services would be able to consider all therapeutic classes of prescription drugs for inclusion on the preferred drug list, including the three previously excepted groups of drugs--antipsychotics, antidepressants, and anticonvulsants. The estimated annual savings of including these groups of drugs is $2,300,000 annually, $936,000 of which is General Funds and $1,400,000 of federal funds. To determine which products will be included on the preferred drug list, the department utilizes expertise of an advisory pharmaceutical and therapeutics committee comprised of physicians, pharmacists, and the public. The committee evaluates the total value of medications, which includes the financial aspects and the clinical aspects. Preferred status is assigned to drugs which have safety, efficacy, or cost advantages over other similar drugs. With the implementation of these three additional therapeutic drug classes, "grandfathering" will apply. This will allow Medicaid clients who are stabilized and compliant on their nonpreferred medications to continue with their current drug therapy. New clients will be expected to initiate therapy with the more cost-effective preferred products. Additionally, there is a process available for prescribers to request a preferred drug list exception. If there is a medical reason why a nonpreferred product is necessary for a patient or if there have been treatment failures with preferred products, an exemption may be provided to the patient. Inclusion of antipsychotic, antidepressant, and anticonvulsant drug products on the preferred drug list would significantly increase the cost savings generated by the preferred drug list. Currently, these three drug classes account for approximately one-third of Nebraska Medicaid program and the Children's Health Insurance Program prescription drug expenditures of about $48 million annually. These classes consist of mostly brand name drug products.

Approximately 85 percent of dollars spent in these three categories are for brand name products. Other classes of drugs have a higher utilization of generic products, on average 75 percent of prescriptions are for brand name products. This implies that the savings generated for these three classes of drugs will be even greater on average than other classes of drugs. Nebraska is one of 45 states with preferred drug lists in place. Of these 45 states, the department found that 39 have at least one of these three drug classes on their PDL. With the guidance of the pharmaceutical and therapeutics committee, we will be able to develop criteria and processes to ensure appropriate use of and adequate access to all three classes. Passage of LB466 will help control prescription drug costs while providing Nebraskans with the medications they need as recommended by their physician. For the reasons outlined here, the Department of Health and Human Services supports LB466. With me today is Barb Mart who is our pharmacy consultant with the Division of Medicaid and Long-Term Care. With the committee's permission, I would ask that she be allowed to help me answer any technical questions you may have. And with that, I would entertain any questions you may have. [LB466]

SENATOR CAMPBELL: Senator Krist. [LB466]

SENATOR KRIST: You know, we as a body get blamed a lot for being lobbied and for them giving us information one way or the other. But on a personal note I wanted to go on the record that I've had a number of...because I have a special needs daughter, a number of issues with bioequivalence where a drug is given to my daughter and it is a brand name drug, and then because we were in the Air Force and forced to use the pharmacy system, we were swapped to a generic drug. And because of bioequivalence and the percentage and the variance, it didn't work as well as others and she almost died from that. Although in fair disclosure, the lobby has brought that to my attention in terms of one drug working better than the other, this is a personal thing for me. And I do understand that we need to balance the budget and balance the books, but on a humane aspect I would say that some of the things that I've reviewed, even in your provider bulletin lists from HHS, lists elimination of drugs that are cheaper before you get to the drug that's actually used and is at full strength and is, in terms of bioequivalence, the preferred drug. Senator Gloor over there said that he was going to make sure that the people who are on those drugs, the drugs that are working, would continue to be able to use those drugs and that the test, as I understand it, once they're on the drug...first question, once they're on the drug, do we have to go through an annual process to recertify that drug for use? [LB466]

KERRY WINTERER: No. [LB466]

SENATOR KRIST: No. So once they're on the drug, they're on the drug, and even with this change in our process, we're not going to force them to come off. So is this a fair fiscal note? I mean, are we looking at the potential of that much savings if everybody

who's currently on the drug is not going to have to change off the drug and everybody who might come into this system who we're projecting might need it...I don't know how to follow that fiscal note. [LB466]

KERRY WINTERER: Well, there's a couple of things in the fiscal note. In the fiscal note was, you said, there is a "grandfathering," if you will. So in other words, if someone is on a drug that doesn't end up on the preferred drug list, they will be able to continue with that drug. And so current clients that have those drugs for whom that drug is working, there will be no requirement. And we've done this by regulation in the past and we will continue to do that with these drugs as we have with other drugs on the PDL. So they will continue to be able to use that drug. It's a very...I will admit that I think it's a very difficult thing to attach a real dollar amount to this. A lot of this has been the result of...Mercer did a study for us at one point in time and they did some projections, and this is after the "grandfathering," but it really anticipates new clients coming on and getting that savings going forward for those new clients. Without the "grandfathering," it could be significantly more than this, so that has been taken into account here. [LB466]

SENATOR KRIST: Okay. That makes sense. And I guess my final question, and you may have to help him out with it, but we have drugs that are fifties, sixties, seventies in terms of technology. We have drugs that are 2010, '11, and probably ripe and ready to release that would do a much better job. How do we get to the point...and probably more expensive admittedly, how do we get to the point of getting them on the best drug? They go through the process of going through the fifties, sixties, and seventies vintage drugs to get to where they need to be? [LB466]

KERRY WINTERER: I can give you kind of a simple answer to that but Barb, I think, can give you a better answer. I think it's a mistake to assume that the new drugs will not end up on the PDL because there's a whole array of criteria that's used in consul with the pharmaceutical and therapeutics committee to determine what ends up on that drug (sic). So you can't just assume that it's the ten-year-old drugs are going to be the only ones on the PDL; it's a matter of what the committee recommends ends up on that list. And it's a function of, certainly, cost-effectiveness but it's also the efficacy of that drug. And many times a newer drug is going to have a higher...is going to be more effective with certain diagnoses than others. So I don't think you can assume it's just going to be the old drugs that are on that PDL. [LB466]

SENATOR KRIST: Okay. Thank you, sir. Is there... [LB466]

BARBARA MART: That was very accurate. [LB466]

SENATOR KRIST: Thank you, Chairperson. [LB466]

SENATOR CAMPBELL: Okay. Senator Cook. [LB466]

SENATOR COOK: Thank you, Madam Chair. I have a couple of questions. The first being, in your testimony you mentioned that if the patient was stabilized and compliant, she or he would be kept on that regimen. Is there a possibility that if they weren't compliant for whatever reason that they'd somehow be recategorized as a new patient and then start with the generic offer? [LB466]

KERRY WINTERER: I think...so much of this I think is really going to be determined by the patient and the prescriber, the doctor. I mean, we don't intend to step in here and dictate to the doctor, well, now you've got to do this, now you've got to do that. And, you know, by compliant we mean someone who is in fact is taking the drug and there's no reason that the clinician would have any reason to change that regimen. If not a compliant, then maybe the clinician needs to do something different, a different prescription or something like that. That's really what it is intended to say. But I think the bottom line here is we don't intend to step in and disrupt the clinician's judgment relative to what should be prescribed. Now do we prefer for a new patient that they prescribe a particular drug? That's correct. But then there is an appeal process and there are ways to work with that clinician, that physician to resolve those. [LB466]

SENATOR COOK: All right. Thank you. And perhaps someone will shed light on it among our handouts, but could you or the program person answer whether or not you know why those drugs were initially excluded from the list? [LB466]

KERRY WINTERER: I don't have a good answer for that question. [LB466]

BARBARA MART: I think only Senator Lathrop could answer that. It was in the legislation. That was not at the recommendation of the department. [LB466]

SENATOR COOK: Okay. [LB466]

SENATOR CAMPBELL: We'll find an answer for you there. [LB466]

SENATOR COOK: Thank you. [LB466]

SENATOR CAMPBELL: I'm sure someone testifying is probably going to do that. Other questions? Mr. Winterer, in the testimony you gave you talked about being able to appeal that and you just mentioned that. [LB466]

KERRY WINTERER: Right. [LB466]

SENATOR CAMPBELL: So at this point, correct me if I'm wrong, if I had a child and that child was prescribed a certain drug and then it would be denied...I'm a whole new patient. Okay. [LB466]

KERRY WINTERER: Right. [LB466]

SENATOR CAMPBELL: And so then it would go to the department and the department would say, no, you need to use a generic, a different...what's on the list here. And we're assuming that the physician is making that appeal. Would the client stay on the prescription that had originally been given until the appeal process is completed or would they be expected to move to the new...what what's on the PDL while they're appealing? [LB466]

KERRY WINTERER: I think I'll defer to Barb to talk specifically about the appeal process. I want to be sure that we're accurate as far as that goes. [LB466]

SENATOR CAMPBELL: Okay. [LB466]

BARBARA MART: I guess first of all, I don't think I totally understand the question. If they're already on the medication, then they'll be "grandfathered," and they wouldn't have... [LB466]

KERRY WINTERER: No, this is a new patient. [LB466]

SENATOR CAMPBELL: No, I'm a brand new person. [LB466]

BARBARA MART: Okay. [LB466]

SENATOR CAMPBELL: But the physician has recommended that Andy Campbell have a particular drug and that's what the physician wants to prescribe, but the department says: No, you are new to the system, it's not "grandfathered," and we want you to use the drugs that are on the PDL. Would Andy Campbell be able to stay on that medication until such time as the appeal process was completed or would Andy have to go on the PDL list during the appeal? [LB466]

BARBARA MART: Okay. So you're saying Andy was on the medication before he came onto Medicaid. [LB466]

SENATOR CAMPBELL: Okay. We need to have you come up to the mike--I'm sorry--because it's not going to...testify...I'm sorry, it won't pick you up. [LB466]

BARBARA MART: So you're saying that he was on the medication and then is new to Medicaid. [LB466]

SENATOR CAMPBELL: Well, I'm trying to...I'm a brand new person to the state of Nebraska... [LB466]

BARBARA MART: Um-hum. Right. [LB466]

SENATOR CAMPBELL: And Andy has not been a client before at all. [LB466]

BARBARA MART: Yeah. [LB466]

SENATOR CAMPBELL: But his doctor is prescribing. At what point does that denial come? Maybe let's start with that. [LB466]

BARBARA MART: Okay. The denial comes at the pharmacy. When the pharmacy fills the prescription, part of their fill process sends a claim to Medicaid, and they get a response that indicates that it's a nonpreferred product. So that's what starts the process. [LB466]

SENATOR CAMPBELL: Okay. But is Andy given the prescription by the pharmacist? [LB466]

BARBARA MART: No, no. If the claim denies, then either the prescription has to be switched to something that doesn't require a prior authorization or the prior authorization has to be obtained. [LB466]

SENATOR CAMPBELL: So then the physician...so let's... [LB466]

BARBARA MART: Now if in the physician's medical judgment they feel that it is medically necessary that this is an emergency situation, there always is the provision for a 72-hour supply if the physician feels it's an emergency. I will say that very rarely do physicians invoke that. They're usually comfortable with going through the prior authorization process, but that certainly is always available. [LB466]

SENATOR CAMPBELL: So in other words, the physician wouldn't send Andy, and let's say I'm the parent here, with him to the pharmacy unless they had checked on a preauthorization. [LB466]

BARBARA MART: As these programs become mature, the physicians very rapidly become familiar with what requires prior authorization and what doesn't, and typically what they do if they know it's a new start, they know what products are available without prior authorization and they will either start on one of those products if they feel that's appropriate; if they don't feel that's appropriate, they will initiate the prior authorization process at the time that they write the prescription. [LB466]

SENATOR CAMPBELL: I'm still trying to get at as a new that if that physician doesn't feel that Andy Campbell is going to do well on the PDL list... [LB466]

BARBARA MART: Um-hum. [LB466]

SENATOR CAMPBELL: ...and wants something else, how does Andy Campbell get that prescription? Do they get that prescription during the appeal or no? [LB466]

BARBARA MART: Now this appeal process is very rapid. [LB466]

SENATOR CAMPBELL: Oh, okay. [LB466]

BARBARA MART: Their prior authorization request is made. There's a set of criteria that is gone through. If they meet the criteria, it's approved; if not, they are given information of what is covered or it's just denied, and in both cases or in all three cases, the response goes back within 24 hours. We're not talking weeks or months. We are talking within 24 hours. But then you always have that 72-hour emergency provision to kind of bridge... [LB466]

SENATOR CAMPBELL: Um-hum. [LB466]

BARBARA MART: ...if it really is an emergency that needs to happen faster than the prior authorization process can happen. [LB466]

SENATOR CAMPBELL: That helps a lot because I couldn't quite ferret out on that. [LB466]

BARBARA MART: I'm sorry I wasn't making... [LB466]

SENATOR CAMPBELL: No, you're fine. You're absolutely fine. We're going to take Senator Howard and then Senator Wallman. [LB466]

SENATOR HOWARD: Thank you. I think it's always good to have an example like that so you can kind of follow how it works in real life. How restrictive or what are the restrictions on getting the prescriptions that is a prescription that is not on the authorized list? What are the criteria? [LB466]

BARBARA MART: The criteria vary from class to class, and the criteria are developed by the PNT committee and an additional advisory board which is termed the drug utilization review board. Both committees are made up of pharmacists and physicians that create the criteria. [LB466]

SENATOR HOWARD: Well, say little Andy came up from Florida and he was on this medication prior and this worked for him and they don't want to change this. So he goes to the doctor and he said, oh, yeah, that's effective and he gets him the prescription

Sure, he's got the 72-hour supply,... [LB466]

BARBARA MART: Um-hum. [LB466]

SENATOR HOWARD: ...but is that criteria going to work for him to this ongoing? After 72 hours, he could be out of luck. [LB466]

BARBARA MART: It definitely will be a case-by-case basis, but if...it would be a decision of his prescriber. If the prescriber feels strongly enough that this medication is necessary, then they will advocate for him and... [LB466]

SENATOR HOWARD: And go through the appeal process. [LB466]

BARBARA MART: Yes, which is just...the appeal process then is a request, goes to the Department of Health and Human Services, is reviewed by the pharmacist and the physicians there. So you've added another day or two onto the process. We're still not talking about an inordinate length of time. And... [LB466]

SENATOR HOWARD: Well, in this situation, how likely is it that little Andy will be approved? [LB466]

BARBARA MART: If the physician feels very strongly that it's appropriate, it will probably be approved. But in most cases in my experience, what happens is the physician says, I don't feel that it's necessary and switches to a covered product. [LB466]

SENATOR HOWARD: So he may second guess what Andy had been on prior and... [LB466]

SENATOR CAMPBELL: Thank you. [LB466]

SENATOR HOWARD: You're welcome. [LB466]

SENATOR CAMPBELL: Senator Wallman. [LB466]

SENATOR WALLMAN: Thank you, Chairman. Yeah, love Senator's parable (laughter) and let's pick up on this. Say Andy decides... [LB466]

SENATOR COOK: Poor Andy (laughter). [LB466]

SENATOR HOWARD: This will be a storybook before we're done. [LB466]

SENATOR CAMPBELL: For the audience, there is an Andy Campbell but he's...

(laughter) [LB466]

SENATOR HOWARD: The ongoing adventure. [LB466]

SENATOR CAMPBELL: I used him the entire time I was on the county board for just such examples and he's 37 years old (laughter) and not very little, but in any case. [LB466]

SENATOR WALLMAN: And it works. [LB466]

SENATOR CAMPBELL: And it works. [LB466]

SENATOR WALLMAN: And it works. Okay. Say Andy Campbell is...this appeal process happens on a weekend or whatever and it's going to be more than two or three, four days. Can Andy Campbell pay the difference between generic and, you know, the brand name? [LB466]

BARBARA MART: Medicaid regulations do not allow that. [LB466]

SENATOR WALLMAN: Oh, huh. (Laughter) [LB466]

SENATOR CAMPBELL: That got a response, didn't it. We'll take Senator Cook. [LB466]

SENATOR COOK: Can Mrs. Campbell pay for it first dollar? [LB466]

BARBARA MART: Yes. [LB466]

SENATOR COOK: Thank you, Madam Chair. Okay. [LB466]

BARBARA MART: Absolutely, yes. [LB466]

SENATOR COOK: Thank you. If she has that kind of cash or credit. [LB466]

SENATOR CAMPBELL: Okay. Any other questions here? Thank you very much for your patience in explaining the example. I have often had questions about exactly how long that took because we've heard about appeals before but not quite understanding. [LB466]

BARBARA MART: Well, this is far different from the administrative appeal process that, you know, those have to be scheduled and there's a hearing and all of that. This is all at a clinical level and the conversations are clinician to clinician. [LB466]

SENATOR CAMPBELL: Okay. It's a wise thing that Mr. Winterer brought you along

today. (Laughter) [LB466]

KERRY WINTERER: Yes, it is. [LB466]

SENATOR CAMPBELL: Any other questions from the senators either for the wise witness or Mr. Winterer? (Laughter) Okay. Mr. Winterer, was there anything we covered that you wanted to add in addition? [LB466]

KERRY WINTERER: No, no. [LB466]

SENATOR CAMPBELL: Okay. Thank you very much. Anyone else in the hearing room who wishes to testify in favor? Okay. We will start with those who wish to testify in opposition to LB466. Good afternoon. [LB466]

LINDA JENSEN: (Exhibits 18-20) Hello. My name is Linda Jensen, L-i-n-d-a is Linda, Jensen is J-e-n-s-e-n, and I'm testifying today for the Nebraska Nurses Association. I'm testifying in opposition to LB466. From our vast experience of nurses administering medications to people with mental illness and/or epilepsy, we know that these medications, even within the same classification, often have biochemical differences, as Mr. Krist said, that result in significant variations in side effects, drug interactions, and effectiveness for each individual. Medicaid recipients who are disabled by a mental illness--and that's usually why they're on Medicaid, speaking of adults--often are very vulnerable and they often have very complex physical and mental illnesses both. So finding the most helpful medications and dosage can take a lot of trials by the practitioner because they vary so much. It's really an individual thing. And the other problem is that in many studies, maybe up to three-fourths of the people quit taking their medications before they maybe even have a chance to see if they're therapeutically effective. Actually--I didn't put this in here--but it takes two, four, maybe six weeks before you know whether that antipsychotic really works. And so, you know, if they're getting a lot of side effects, what would you do? You quit taking them. Other states have restricted antipsychotic medications for Medicaid recipients. There was a study of antipsychotic restriction in ten states--California, Florida, Georgia, Massachusetts, Michigan, New York, Ohio, Pennsylvania, and Tennessee--and that reported that patients in states with more medication...that had medication access problems, such as restrictions for antipsychotics, had significantly higher rates of adverse effects. And those with the highest rate of medication access problems had two point three greater odds of experiencing an adverse event. So when they experience an adverse event, you know, they could be hospitalized, they could go homeless, they could commit crimes, what else could happen, you know, when people quit taking their antipsychotic medications. So California showed similar problems. North Carolina showed similar problems. Georgia showed similar problems. And the wonderful thing is now that there are some very good antipsychotic medications and hospital costs, you know, we don't have nearly the large hospitals that we used to have as far as the regional centers and

etcetera, so people can recover. People can get better. They can go back to work. They can have very productive lives. But they have to have a medication that works for them. Now I'm going to get a little bit away from my written testimony to some of my other things that I handed out to you because I also had handed out a personal testimony from me and a testimony...or a letter from a nurse practitioner. And I just want to give a little bit of my background. I have a son who has schizophrenia. When he first was diagnosed, they gave him...I don't know what they gave him, Haldol, whatever. It was the worst thing I ever saw. He shook all over. He just looked awful. At that time, Clozaril had just come out, and they said: Oh, no, that's a new medication, it's too expensive. Well, after failing, (laugh) failing, failing, and trying to commit suicide, they finally decided...almost, was really close, he was unconscious, they finally decided that he could try Clozaril. It was the difference between night and day. It was wonderful. And today he is working on a master's degree in counselling. He's a peer specialist at the psychiatric hospital, and he's an amazing person. So I guess I think you need to let them have a chance. The other thing is that I teach family to family classes for the national lights on mental illness. And I am puzzled by the fact that a couple of the people that I have worked with recently in the classes have told me that their child who is on Medicaid who gets their...and Magellan I guess is the preauthorization entity for that, they've had trouble getting their kids on medications that might work better for them. I know this one lady said that for several months...and they've written...they've done the appeal and it has been denied, and her son is still continuing to be very psychotic. He punches holes in the walls when he gets mad. He is very upset. And they just can't get him switched to some of the newer medications that might work. And another one just the other day told me what had happened was, her son...they had switched meds and the new one didn't work, so she wanted to go back to the old one. Well, then they said, well, that old one isn't on our list anymore, you can't have that one, so. [LB466]

SENATOR CAMPBELL: You may want to check with an expert that's here, double-check. [LB466]

LINDA JENSEN: Well, what I told her, maybe they just should call the "ombuds" person because I don't think that's the intent of the law the ways it's written now. [LB466]

SENATOR CAMPBELL: Right. Question? Oh, sorry. Questions for Ms. Jensen? Thank you for coming today and telling us your story about your son. [LB466]

LINDA JENSEN: Thank you. [LB466]

SENATOR CAMPBELL: Next testifier in opposition? [LB466]

CHERYL CROUSE: (Exhibit 21) I am Cheryl Crouse, that's C-h-e-r-y-l C-r-o-u-s-e. I am from Kearney, Nebraska. Thank you for the privilege of allowing me to be here to testify.

I also serve on the Governor's advisory committee on mental health affairs. I am committed to advocacy for my peers and myself. This bill is of special interest to me. Having had mental illness for almost 30 years and on medications for most of that time, medications can be friend or foe. Six years ago, I was working full time as Nebraska's first peer specialist. I was also working on year three of my master's degree in social work, traveling to UNO at least one day a week. My psychiatrist switched me to a different mood stabilizer, hoping it would help with the long hours driving and the long hours working on my degree, and also working as peer specialist. Slowly my classmates began to tell me that I was becoming more quiet. Talk to us, they'd urged. Tell us more stories about your job. They just fit in with what we're studying. Cheryl, you're becoming...where are you? You're becoming so quiet? I didn't know I was. I only knew it was becoming more difficult to work on the tests. I didn't have the right answers on the tip of my tongue in class. The anecdotes from work that fit in before just weren't there anymore. Writing papers was harder and harder. I finished the two semesters of class work--my last classes. Now to just finish up my practicum and take the big test and graduate. I was ecstatic. No more traveling up and down that interstate to Omaha from Hastings. For a woman of almost 50, that was a trip. I found a practicum at the regional center. It wasn't ideal, but the school...and the school did not fulfill their part, and the supervisor at the regional center was stacking things up against me. There was so much stress. In Omaha, I went to the school to take final exams and my instructors didn't even recognize me because my face had changed so much. I had a totally flattened effect from the effect of the medication. I had studied for hundreds of hours for this final exam, but I had no confidence that I would pass. An instructor had looked at my computer screen and, although I had tried for four hours to put meaningful, thoughtful answers to the questions, what I had on the screen looked as though a four-year-old had played for a few hours. I was unable to send it as a document back to the school and had to ask for help, another cue that I wasn't thinking clearly. I was called back for oral exams and by then, I could not find words to pull from my mouth at all. The school had arranged a meeting including my husband for that afternoon. The instructors that I had come to love and respect for their observances said: What is going on? Cheryl is very sick. Haven't you seen this happening? My husband, in fact, had not seen it happening. He was too close. My life had been stolen very slowly, minute by minute. Anyone who was close to me didn't see it happening. Only people who knew me and were separated for a time from it saw the difference. The instructors talked over me. They didn't even try to talk to me. They gave me six months medical leave, and then the possibility of repeating the practicum, finals, and etcetera. The medication had destroyed my short-term memory and language areas of my brain. It has never come back. My dream was never to be realized. An older medication prescribed to me meaningfully, all good means, even monitored, had caused a severe brain injury. Failing, an old medication didn't mean it not working, it meant destroying my brain. I have worked in a day rehab setting for nearly six years and in the regional center for a year. It was easy to tell who were taking their meds and who was not, who were on newer meds and who had been on the older meds for years and years. The people who

were on the newer meds and who had been on the older meds for years and years are able to speak clearly, think clearly, and at the very best, hold a job. To have to fail at older meds before they can even try new meds risks all of the side effects like traumatic brain injury, like happened to me. Don't pass this bill. It can harm people. People with mental illness deserve the best treatment that we have. The sooner that they're put on the best medications, the sooner they're able to be able to rejoin the work force, their families, and even better. [LB466]

SENATOR CAMPBELL: Questions for Ms. Crouse? Thank you for coming and sharing your personal story very much. [LB466]

CHERYL CROUSE: I had worked meaningful jobs. Until that time, I have not been able to work since. I want to work. [LB466]

SENATOR CAMPBELL: Thank you very much for coming. Next testifier in opposition to the bill? Good afternoon. [LB466]

CHERYL BUDA: (Exhibit 22) Good afternoon, senators. My name is Dr. Cheryl Buda, C-h-e-r-y-l, last name is B-u-d-a, and I'm a board-certified psychiatrist in Omaha, Nebraska. On behalf of the Nebraska Psychiatric Society, an organization of psychiatric specialty physicians, I am here to present testimony in opposition to LB466. As you listen to the testimony, read the letters regarding this bill, and look at who is in opposition to this bill, you will see that these are the people that truly understand what this bill would mean to the population of which it's trying to serve. You will notice that the Nebraska Medical Association is opposed to the bill. You will notice that the Nebraska Association of Behavioral Health Organizations is opposed to the bill. The APA is also opposed to this type of legislation. As we just heard from Cheryl who's a consumer and who has been affected by these things, these are the people that you should be listening to because they understand what this could do to the population. The apparent justification of LB466 is cost, and just like it was discussed in the beginning, I do not understand where those figures are coming from. Absolutely don't understand that at all. And I think that before you make any decision on this, you need to know exactly how those numbers are being figured out because I can tell you if this does go through, the state of Nebraska should have a big pile of money to deal with the ramifications of it. There's been so many studies as the nurse presented: the Medicaid study in ten different states that found that there was increased hospitalizations, increased emergency room visits, increased psychotic episodes, incarcerations, violence. These things are going to occur. As a psychiatrist that sees psychotic patients or severely depressed patients in my office each and every day, switching medications is probably the number one factor that leads my patients to go into the hospital. And I'll tell you now that the appeal process for whether you have great insurance or whether you have Medicare or whether you have Medicaid, the appeal process is not rapid as people have said because I fill out these forms. I give out these medications. I get the form that it's

been rejected. I fill out the long form, which it's very long let me tell you. They want to know previous meds that you've tried; dates and times; why it failed; other medical conditions that could be contributing. These are not like two-second things. We, in fact, in my office hired, had to hire a woman and that's her job is to try to get these prior "auths" and try to appeal these denials. And so it's not rapid, and I want to tell you that right now. And it's something that this bill, you know, is going to cause major, major problems in that because if I have a psychotic patient sitting in my office, I want to get them stabilized fast and I want to keep them stabilized. And if I know what medication I think will do it, I want to give it them right then and there. And this...if this bill passes, that ain't going to happen. I think you have to think about a couple of things. Drugs are unique. We're not talking about blood pressure medications, diabetic medications, those kind of things. We're talking about psychotropic medications that affect the brain. These are very unique. I could give an antipsychotic to someone, high, high dose, and give it to the next person and it don't do nothing. They're very different. Also, you have to think about prevention. We need to work on preventing episodes, preventing emergency room visits, preventing going into the hospital, preventing going into the prison system, prevention, and not just deal with the ramifications of it. This is a vulnerable population. I think we need to do everything in our capacity to take care of them. On page two, I reflected on some of the recent studies that have been done, and you can look at the figures and it's pretty staggering if you look at those figures. Seventy-four percent of people that did not have access to medications; they ended up in the emergency room. Seventy-two percent had longer hospital stays. And I'll tell you, to stay in a hospital, in a psychiatric hospital in Omaha, Nebraska, it's about $1,000 to $1,500 a night. Okay? And it's not uncommon that some of my patients if they become unstable, that they have to go into a hospital and spend not two nights, maybe three weeks, two months. This happens and it needs to be addressed. And it's a different population and we need to protect that population. One last thing, I know I'm supposed to stop, but, you know, I don't know how this is occurring but it's been brought up to my attention by many doctors and I said that I'd present it, is some of the doctors that work with indigent populations, which I don't because I'm a private practice psychiatrist, but doctors that work with indigent that don't have anything, they have social workers that get the patients onto Medicaid. Okay. They are stabilized with, you know, really, the good injectable antipsychotics that work great. There are patient assistance forms, you know, like doctors will get these indigent patients on these drugs. Then they get onto Medicaid and you're like, woo who, we're on Medicaid, but no. There have been provider bulletins sent to doctors saying you cannot use this drug, you cannot use injectable Invega or some of the new ones. You have to fail Haldol, Prolixin. And I don't understand how that could even be possible as the statute is written right now. So I'm not sure what that is all about, but lots of doctors have complained about that. And I think that, you know, the state of Nebraska needs to send a strong message to the federal government, to its own Medicaid consumers, and to the community that we are going to give doctors every available option to treat these patients. You know, a state like how you think about your state should be how well you treat the most vulnerable people in your state. [LB466]

SENATOR CAMPBELL: Are there questions for Dr. Buda? Senator Howard. [LB466]

SENATOR HOWARD: Thank you. Thank you for coming in. You've certainly given us a lot of information that we need to have. One of the real disadvantages that I see of putting people on a medication that may or may not address their illness because this is what's recommended is they're not in a controlled environment. When you give them the script and you're not feeling this is what you think is going to address the problem, I can only imagine how you must feel letting them go out with that. [LB466]

CHERYL BUDA: Oh, absolutely. When I see a new patient for an hour, I have a good idea. This is the medication that I think would be best for them given their medical problems, given their side effects, given the whole realm of this. I'm not...cost is only a portion of that, it has to be as a doctor. You want to prescribe the meds you think is going to work. And when I send this patient who's severely depressed and maybe is paranoid and a little psychotic out the door, I want to have my name on a med that's going to work. I don't want to be using little fail-first kind of meds... [LB466]

SENATOR HOWARD: Right. [LB466]

CHERYL BUDA: ...and worried that, what's this person going to do? [LB466]

SENATOR HOWARD: Yeah, I think that puts you in a really compromised position. [LB466]

CHERYL BUDA: Absolutely. [LB466]

SENATOR HOWARD: Okay. Thank you. [LB466]

SENATOR CAMPBELL: Dr. Buda, you mentioned that your patients are mostly private pay. [LB466]

CHERYL BUDA: Correct. [LB466]

SENATOR CAMPBELL: Would that be correct? [LB466]

CHERYL BUDA: Um-hum. [LB466]

SENATOR CAMPBELL: And that you don't take Medicaid. [LB466]

CHERYL BUDA: I do have people that have "grandfathered" into our clinic, so I don't just kick them out the door. [LB466]

SENATOR CAMPBELL: No, I understand that. [LB466]

CHERYL BUDA: You know, I keep them. And the thing is, is that...I'll give you a perfect example. I had a patient that's Medicare/Medicaid. She became psychotic. She's sitting in my office completely psychotic, and I wanted to change her from risperidone, which is a generic antipsychotic, to Zyprexa, which is not a generic antipsychotic. I send her out. It's Friday, of course it's got to be Friday, right? So I send her out; gave her the prescription, actually I called it in. Later that night they call me and say, you know, it's not covered. I said, this is a Medicaid patient. And they said, no, this is a Medicare/Medicaid patient. I said, oh, okay. So that lady, she can't afford to pay for this on her own, I mean, that's not an option. So she had to stay on this generic...they didn't give her no samples, I'll tell you that, she stayed on that risperidone over the weekend and ended up in the hospital on Monday. Is that cheap? No. You know, and thank God nothing happened over that weekend. You know, and this happens. [LB466]

SENATOR CAMPBELL: In your practice of working with private patients, do you run into...and I don't know whether I want to say a lot or a number of times in which if the person has private-pay insurance, do the insurance companies turn you down? [LB466]

CHERYL BUDA: Absolutely. Yes, they do, you know, sometimes. [LB466]

SENATOR CAMPBELL: Oh, so the person who's applying... [LB466]

CHERYL BUDA: But then the thing is, the thing is that patient then can say, you know what, this med is working for me so I'm going to pay for it. A Medicaid patient can't do that. They can't just pay for that. They're on Medicaid for a reason. And so there's a big difference and I think that difference has to be clearly understood, you know, because I have private-pay patients that say, okay, you know, I want to stay on this antidepressant that's... [LB466]

SENATOR CAMPBELL: Yeah. [LB466]

CHERYL BUDA: ...not generic and I will pay for it. [LB466]

SENATOR CAMPBELL: I was just trying to figure how much push back you were also getting. [LB466]

CHERYL BUDA: Oh, you get push back everywhere, you know. [LB466]

SENATOR CAMPBELL: Okay. Thank you, Dr. Buda, for coming. [LB466]

CHERYL BUDA: Okay. Thanks. [LB466]

SENATOR CAMPBELL: Next testifier. Good afternoon. [LB466]

TIMOTHY CUDDIGAN: (Exhibit 23) Good afternoon, Senator. My name is Tim Cuddigan. I'm the president of NAMI Nebraska. My last name is spelled C-u-d-d-i-g-a-n. NAMI Nebraska, the National Alliance on Mental Illness Nebraska, NAMI is a grass-roots organization that is dedicated to improving the lives of individuals with mental illness through research, support, and advocacy. On behalf of NAMI Nebraska and the Nebraska Association of Behavioral Health Organizations, we oppose LB466 for the reasons that I've set forth in my letter. And I'm going to deviate a little bit from my script because a number of people before me have made these comments, but I'm going to go sort of right to the heart of things. Prior testifiers have referred to the Medicaid study. I've provided you with a copy of the Medicaid study comparing the ten states and the adverse events that the PDL legislation accomplished in those states. What I want to do is, there's been a lot of discussion this afternoon about the fiscal note and the fiscal responsibility and so on. And as Dr. Buda alluded to and also as prior speakers alluded to, what these fiscal notes aren't accounting for is two things: one is the human dignity and the human misery that these fail-first policies inflict upon a vulnerable population. That's number one. Number two, what these fiscal notes don't really account for which I think is very important is, what is going to be the increased cost in the emergency room visits, as Dr. Buda indicated; what is going to be the increased costs in hospitalizations, as Dr. Buda alluded to; what is going to be the human cost in suicide attempts, homelessness, and the change in the dignity of these individual's lives? So we can talk about economics and everyone of us is concerned about the deficit, and everyone of us is concerned about how are we going to pay the state's bills, but the fact is, is that not everything is dollars and cents and sometimes numbers are sort of put together with an illusion here. And I want everyone to understand that while we're concerned about the fiscal health of this state, we're also concerned about the dignity of the most vulnerable citizens. And that's very important in the fact that we can't use these drugs just to fit in slots like their cholesterol drugs. They have different effects and they have different side effects, they have different effectiveness. So I don't want anyone to leave here today with the impression that this is just a dollars-and-cents equation. Thank you for your time. We'd ask you to not allow this to go out of the committee. [LB466]

SENATOR CAMPBELL: Thank you. Are there any questions? Mr. Cuddigan, thank you for bringing in the article for us. [LB466]

TIMOTHY CUDDIGAN: Okay. [LB466]

SENATOR CAMPBELL: Next testifier. Hello. [LB466]

DEBRA CAMPBELL: (Exhibit 24) Senator Campbell, thank you. My name is Debra Campbell, no relation. (Laughter) [LB466]

SENATOR CAMPBELL: Maybe we could be. You never know. [LB466]

DEBRA CAMPBELL: Well, it's the largest clan in the world so it's a possibility. [LB466]

SENATOR CAMPBELL: Ah, I didn't know that. [LB466]

DEBRA CAMPBELL: It's spelled D-e-b-r-a C-a-m-p-b-e-l-l. I come as both a professional and a personal story. I have been an RN for 30 years. I currently serve in an intensive care unit in Omaha, Nebraska, and I have done that for 22 years. I also...but more importantly to me is I have been married for 30 years. The love of my life has epilepsy. So I'm going to change your focus a little bit from mental health to epilepsy and how this bill might affect us and why we do not agree with it. My husband is one of the unlucky people that is not able to be controlled by medication; 70 percent are. That's why the medications associated with this bill are so important. The trick to getting the medications right is you have to do lots of trial and error. My husband, unfortunately, was on the older medications for 25 years or more, because of that he has a huge cognitive deficit. He was not going to an epileptologist because that was not an option in this state up until the last few years. We only have two in the Midwest region, and they are current on the medications. And now that he's on those medications, he is better controlled. The letter that will come around from me will sound familiar to you. A week ago, I was not thinking I would be able to be here today because he was going to go into the hospital on Monday for a controlled reduction of his medications, and because of that being so graphic proving that he needed the stronger, newer, more expensive medications--that's why I'm here--he was off his medications for 12 hours and had eight major seizures, and it took 36 hours to recover from that. Luckily he's having a good day today, so he is here with me. This gentleman has three degrees in computer programming, computer building, electronics. Because of his cognitive function, his reading is almost nil. He cannot see the computer boards to see...to do them. He can't build computers anymore. But it's very important to him that he not be on disability, so he has found a position working in the housekeeping department of one of our local hospitals. He chose that because it's very close. He cannot drive anymore, so between my sons and I, we can get him to and from work. But simple things like taking public transportation is an issue because if he were to have a seizure and fall and hurt himself taking public transportation, he's very, very limited in what he can do. Some of the things that were brought up that I would like to address on a personal level. Senator Cook, you mentioned how could Mrs. Campbell go pay for his medications if she wanted to. Let me use myself as an example. My husband's medications right now, and I do have private insurance through my job, they cost us $475 a month. If we did not have that insurance, it would be $2,500 a month. I would doubt that a senator is paid well enough that she could come up with $2,300 a month (sic). Most of us cannot. And these are the medications I was able to get. We appealed for other medications. I don't know how the Medicare appeal system works but I will tell you in my instance, I called

the company, said the doctor really wants him to be on XYZ medication. And she said, well, we don't approve of that one. She said, but we do have an appeals process. The appeals process consists of you write a letter, the doctor writes a letter to us telling us why he has to be on these more expensive medications, and we write you back telling you why he can't have them. Would you like that address? No, thank you. I didn't think it would do any good. So he's on six different medications right now to try and control it. He still has anywhere from one to three to five seizures a week. We're very careful to make sure he does not have a head injury that would cause him permanent disability because that is one of my fears with this bill is, if he has a severe enough head injury or something else might happen, he will be a portion of this bill on Medicaid. And the medications he's on are expensive. He will probably not be able to get these medications and will go back to having the 10 or 12 seizures a day. The stronger medications, the more expensive medications are frequently the long-acting medications. As long as you only have to take a medication one or two times, it's very easy to stay compliant with that. If you're taking the cheaper, older medications that you may have to take four or five or six times a day, all of a sudden compliance becomes very poor. They talked about how there will be a committee set up of physicians that will monitor, you know, what medications will be approved. I have learned, and this shocked me, that the physicians in medical school receive a 40-minute lecture on epilepsy, frequently not taught by a neurologist. It's occasionally taught by an EEG technician. That is the sum total of their knowledge of epilepsy and seizures. They rely on those drug reps to tell them what's new in the market. They can't possibly spend 24 hours a day reading up on every single medication that is out there for all different diagnoses. Most of our medical care comes from our primary care physicians which can't keep up on everything, so they rely on those physicians. I would thank you very much and I would be open to any questions you might have. [LB466]

SENATOR CAMPBELL: Any questions for Ms. Campbell? Thank you for coming in today... [LB466]

DEBRA CAMPBELL: Thank you very much. [LB466]

SENATOR CAMPBELL: ...and I hope that we are related somewhere. Next testifier. Good afternoon. [LB466]

DALE JOHANNES: (Exhibit 25) Thank you, Senator Campbell. Thank you, Senator Campbell. Thank you, members of the committee. My name is Dale Johannes, last name is spelled J-o-h-a-n-n-e-s, and I'm here today to speak on behalf of my wife, Michele. I met my wife six years ago with the help of an on-line service called eHarmony. Somehow fate brought us together as we both had similar goals in life. Our first correspondence was done via e-mail. I'll never forget what she said in one of her first e-mails. She wrote: Here's the story, Dale. I have epilepsy. If you're not okay with that, then I understand and we can both go our own separate ways. It was at that

moment that I knew I'd met the right person. I had suffered a brain injury at the age of 17. I knew what she had been through and she understood my life as well. My wife runs a local epilepsy support group here in Lincoln. She's devoted the past several years of her life advocating for people with seizures. In the time that I've known her, I've seen her have many seizures. I've seen her go from complete bliss and happiness to complete despair, shaking, trembling, and overwhelming fear because of a seizure. I know that Michele's seizure control is almost entirely dependent on the medications she takes. Her medications over the years have been measured and monitored. I've heard her say that it is more an art form to keep the right balance in your blood stream of medication. This is key to being seizure free once you find a medication that works. If my wife gets sick with a cold or any type of ailment that requires any antibiotic, she risks throwing that delicate balance off. I've seen her have multiple seizures due to antibiotics interfering with her seizure medication. Seizure thresholds are lowered sometimes when other drugs are introduced into the system. Something as simple as not getting enough sleep can interfere with her seizure control. It's so important that my wife maintains this delicate balance that she has paid a $380 copay for a seizure medication instead of filling her prescription with generic medications. We have been lucky enough to be able to afford this type of medication that she needs; others are not as lucky, and sometimes people with epilepsy will switch between drugs to a drug that they can afford. Sometimes that may mean taking a generic which could vary from bottle to bottle or manufacturer to manufacturer or could mean taking an entirely different medication that may not be as effective for the type of seizures that someone has. When my wife can go days, weeks, or months without having a seizure, it's a true miracle for her. She never takes a seizure-free day for granted. I'm asking that you think about my wife when you consider the changes to LB466 and all the lives of the people she's affected. Is there any question? [LB466]

SENATOR CAMPBELL: Questions? Your wife is very lucky to have you, sir. [LB466]

DALE JOHANNES: I kind of look at the...(laughter) [LB466]

SENATOR CAMPBELL: She is. Thank you for coming. Next testifier, please. Good afternoon. [LB466]

GINA SIMANEK: (Exhibit 26) Good afternoon, Senator Campbell and all of the committee members of Health and Human Services. Thanks for letting all of us be here today to say what we need to say. I'm, of course, in opposition of LB466 and I'm here today to speak on behalf of the Brain Injury Association of Nebraska. [LB466]

SENATOR CAMPBELL: And your name is? [LB466]

GINA SIMANEK: My name is Gina Simanek, G-i-n-a, and then S-i-m-a-n-e-k. So I'm here for the BIA Nebraska as well as I do a lot of outreach work for people with...or

individuals with brain injuries. I think my goal here today because a lot of this has already been stated is I wanted to really pass on information about the chemical changes. When a person has a brain injury, there are a lot of chemical changes that occur. And I also wanted to state the fact that in the state of Nebraska, there's about 3...there's over 300...or it's estimated to be 307,000 people living with brain injuries. And when I'm talking about brain injuries, I'm talking about seizure disorder, traumatic brain injury, shaken baby syndrome, meningitis, encephalitis, the blast injuries coming from the war. It involves a lot of people, and I'm not just talking about myself and the people that are represented here today but it could happen to you tomorrow, and we all have to realize that. Again, the chemical changes occur when the neurons are brought against the brain skull and they're torn apart, they're sheered. Again, the chemicals go into the brain, various areas of the brain as well as the brain swelling, the level of blood increases, the contusions against the brain, and this is all a very difficult thing because the individual doesn't really know what's been changed until hours to days to even months later. Another thing I wanted to mention is that, you know, yes, people have their personal physicians, they have neurologists, they have psychologists, neuropsychologists who all know this person well. However, they don't see the after effects later on in this individual's life. Therefore, this is why this LB466 is going to be so bad because, you know, you speak with the neurologist...and nothing against them because they don't see this individual years later, but there's a lack of continuity of care. And that's what we're trying to work on right now. And in working with one individual that I provide outreach work for, I'm going to call him Smitty, he had...of course most people with brain injuries, they also incur a severe level of depression as well as a severe level of anxiety. That all goes along with the brain trauma because everything in their lives has changed whether it be physiological, emotional, cognitively, the chemical changes, behaviorally. But this Smitty guy, I've been seeing him for the past six years, but he had had a boat accident where he got a brain injury. This boat accident allowed him to have a severe brain trauma and it also induced...the chemical changes also induced a level of major depression. And he went into his general practitioner and he prescribed him with...let's see, what's it called, it's called Seroquel, which is an antipsychotic which is often used in conjunction with an antidepressant. This antipsychotic caused him to gain weight, which is a typical side effect. He had a bad reaction to Dilantin or to, I'm sorry, to the Seroquel, so then he prescribed him Dilantin. With the Dilantin, he lost his short-term memory. Again, he was just about ready to become a productive member of society; had to back down just like the gal who earlier spoke had to also. So there's...you know, people always react differently to medications, and the personal physician, the neuropsychologist, the psychiatrist isn't always going to know but, there again, it's let's try and see. So there again, people with brain injuries and mental illnesses, this is a large population, like I said, over 307,000, and that's just the traumatic brain injury population; that's not including strokes, shaken baby, etcetera, or the seizure disorders. And I just wanted to get those points across. Do you have any questions for me? [LB466]

SENATOR CAMPBELL: Any questions for Ms. Simanek? Thank you very much for coming and providing your testimony. [LB466]

GINA SIMANEK: Thank you. [LB466]

SENATOR CAMPBELL: Next testifier, please. Good afternoon. [LB466]

LAURA NEECE-BALTARO: (Exhibit 27) Good afternoon. I am Laura Neece-Baltaro, L-a-u-r-a N-e-e-c-e-B-a-l-t-a-r-o, and I am here representing the Epilepsy Foundation which is opposed to eliminating this carve out. These are different drugs, as many have said. The only thing I really have to add is that the costs are extremely high in the case of epilepsy. And unless you can tell me that there will be an epileptologist on that doctor review board, I will not be satisfied because epilepsy is difficult to treat. Normal, everyday doctors do not have the expertise to treat difficult cases of epilepsy. Epileptics risk brain damage with every seizure they have, and further brain damage makes them less functional in our society: They require more care. They require emergency room visits. They require more doctor visits. They require more support services. The cost to eliminating this carve out is very high. There was a reason why it was put in there initially. These are a different class of drugs. I have an analogy. It's like we all know how cold it was last week. Okay, you don't have enough money to pay your heating bill. You turn off the heat to save money, and then what happens? Your pipes freeze and you have thousands and thousands of dollars of damages to repair just to save a few hundred dollars. That's what we're doing here. [LB466]

SENATOR CAMPBELL: Any questions? Thank you very much for coming today. Next testifier. Good afternoon. [LB466]

LINDA CARROLL-SHERN: (Exhibit 28) Senator Campbell, members of the committee, thank you for allowing me to testify today. My name is Linda Carroll-Shern, Linda, L-i-n-d-a C-a-r-r-o-l-l-S-h-e-r-n. I am here today representing PhRMA, Pharmaceutical Research and Manufacturers of America. PhRMA represents the country's leading pharmaceutical research and biotechnology companies. First of all, PhRMA would like to commend Senator Gloor's amendment to keep patients on their current medication. However, it's our understanding as he was describing the amendment that new people would still be subject to the PDL. So all the concerns we've heard today still stand. We have heard compelling testimony, so I will cut my testimony short but would like to mention one thing. PhRMA realizes the budget difficulties facing Nebraska as well as many other states. Many states are looking for ways to save money and cut costs. PhRMA doesn't believe that denying mental health patients access to mental health drugs will save money. One area to look at for cost efficiencies might be the coordination of the preferred drug list process and the drug use review process. These are two processes that determine what medicines Medicaid patients receive. Contrary to current law and contrary to the intent of the current law, some mental health drugs

are already being included in prior authorization processes. Patients are already being affected and not having access to some of the mental health drugs that they need. Dr. Buda referenced this when she was testifying, and she said to the committee: What is the problem? This is the problem. It's part of a different process that's occurring. So by passing LB466 and putting these mental health drugs on the PDL, you will only exacerbate and have additional access issues. A study resolution, LR466, that was introduced last session by Senator Campbell wanted to look at the Medicaid drug program and access issues like we are discussing today. Unfortunately, the state's budget challenges and federal healthcare reform consumed the committee's available study time, and we certainly understand that. We would respectfully request that another study be conducted over the interim to further evaluate these access issues, some of which we have been hearing about today and the negative outcomes that may occur to patients because of these different inefficiencies and lack of coordination between the DUR and the prior authorization committees. In closing, PhRMA opposes the inclusion of antidepressants, antipsychotics, and anticonvulsants on the Nebraska preferred drug list. We have concerns that mental health patients will adversely be affected and that negative health outcomes will occur. Physicians and their patients should be the ultimate decision makers when dealing with this class of drugs. Thank you for allowing me to address the committee, and I would be happy to answer any questions. [LB466]

SENATOR CAMPBELL: Any questions? Thank you very much for coming. Other testifiers in opposition to the bill? Anyone testifying in a neutral position? If not, Senator Gloor, do you have any closing comments? [LB466]

SENATOR GLOOR: Thank you, Senator Campbell, fellow committee members. Difficult subjects, difficult decisions, and we've just started, and I mean that in all sincerity. We have just started the process of trying to decide. And, as one of the testifiers said, this is about money. Absolutely. I mean, we are here in a budget crisis sitting down trying to take a look at ways that we think we can make budget decisions, and we certainly don't want to make budget decisions that adversely affect Nebraskans. And we certainly don't want to make decisions that instead of saving us money, cost us more money. I clearly understand that. Let me go back to Senator Bloomfield's mulligan, if I might, just as a way of concluding and summing up things. One of the testifiers really put their finger on one of the interesting comments that nobody...I hope you listened to and heard, and that is most of the time when a physician or the clinician picks up the phone and calls in to begin the appeals process, they agree with what they're told with the individual on the other line. Most of the time that happens and you have to ask, but how can that be? And once again, how are we saving these large amounts of money if we're just talking about rolling in new people that come into the system? That is one of the amazing things about a PDL. By the way, you had a whole large number of people who were nurses who testified who I'm sure work for institutions that have PDLs that include these medications. It's that you have that communication. It is as one of the testifiers said, too

many of the practitioners get their information from the drug reps. You heard somebody say that and that, in fact, is true. Not the people in this room (laugh) who, because they have such a strong interest in this, I'm sure are up to snuff on their pharmacological science, but that's not true across the board. Whether it was in my institution or whether it involves a lot of care in mental health, a lot of those clinicians are so busy, don't have a lot of exposure to the studies of meds and new meds that are out there, and as physicians told me, I count on my drug reps for a lot of the information of what's new and what's available. When they have a chance to visit with somebody who does this on a full-time basis, a pharmacist...and remember, the PNT committee that we have here at the state has four pharmacists and a faculty member who's a pharmacist, when they have a chance to find out what else is available, it ends up being an education and an opportunity. Not just tightening the screws and squeezing money out of the system but an opportunity for them to both improve care in some instances and save dollars in other instances. I will try and come back to the committee and talk to you just a little bit about the hearing when this first PDL came through. Remember, we've had it in place now for a while. And I understand the hearing was even busier, even more packed, even more full of: this isn't going to work. The appeals process isn't going to work, and it appears to have worked. It appears to have worked. And some of the same people who were here testifying that it wouldn't work were there saying it wouldn't work. It appears to be working. This is going to be a long session. We're going to have to make some difficult, difficult decisions and this may not be one that we want to make, but at least this is a decision where the first largest move was already made to go to a PDL. There was an infrastructure in place to protect patients, to provide for appeals. And we may be, in the upcoming months, looking at...upcoming weeks anyway, looking at other bills that we have to make difficult decisions on that don't have a safety net like this does. It's not a safety net that obviously is one of comfort to a lot of people, but I would tell you of some of the bills that I have looked at, we have a system. The state has upheld its bargain going to this first PDL. I think this is an appropriate bill to move forward with for all of those reasons. Thank you. [LB466]

SENATOR CAMPBELL: Senator Bloomfield, you get first up here. [LB466]

SENATOR BLOOMFIELD: At the risk of sounding like the mean ogre here and I don't intend to, from what I gather, what I pick up here, it sounds to me like we are possibly...this is going to be a terrible analogy, I'm going to use it anyway, Chevrolet and "Cadillacing". Are we...by not doing what your bill suggests, are we putting the Cadillac out there first when maybe the Chevrolet will do the job? Since your bill protects anybody that is currently on...with your amendment, somebody new coming on, are we not automatically now putting them in the Cadillac instead of putting them in the Chevrolet? [LB466]

SENATOR GLOOR: Well,... [LB466]

SENATOR BLOOMFIELD: And I realize that's a terrible way to go about it. [LB466]

SENATOR GLOOR: Yeah. I'm not sure how I'd characterize it in a metaphor. I would say this: If Andy Campbell were moving from Florida up to Nebraska and he were a Blue Cross Blue Shield patient, he would be going through the same process that we're talking about as if he were going from Medicaid in Florida up to Medicaid in Nebraska. I mean, if you're covered under insurance, you will, as you call in for medicines, have to go through some sort of process. And I think the answer to that depends upon: Was that individual coming from a private insurer to the state? Were they coming from no coverage to the state coverage? From what I know what the state goes through and the appeals process the state has in place...and one of the testifiers talked about the hassle they had with what appears to be nothing more than just, that's not on the list, you don't get to do it, but that, as I recall, wasn't Medicaid; that was a private insurer. And we do better than that for the wards of the state. We have a pretty elaborate system in place, and people who move into the state system, I would say depending upon where they're coming from, are moving in most cases to a better, more thorough system with more checks and balance and not built around a profit margin. [LB466]

SENATOR CAMPBELL: Senator Bloomfield. [LB466]

SENATOR BLOOMFIELD: I guess my question relates more to somebody that's newly diagnosed rather than somebody that's coming in that's already on medication. [LB466]

SENATOR GLOOR: Okay. [LB466]

SENATOR BLOOMFIELD: Are we at that point, going back to my poorly chosen automobile? Are we telling the doctor, no, do not put them in the Chevrolet at all, move right to the Cadillac because you know that works? This may work but don't try it because it's on that PDL. And I... [LB466]

SENATOR GLOOR: I'm guessing that that would be a question that is going to be diagnosis-specific and depend upon the PDL or formulary that's put together by the committee. I mean, I heard testimony from the department that sometime it's moving them to a better medication that might be more expensive. And so my answer to you would be somebody newly diagnosed may, in fact, be getting the benefits of the newest science that's out there; maybe we'll be getting that. Since there's some time and effort, it appears the state is putting into staying up-to-date with eight physicians and four pharmacists and a faculty member and a couple of folks. [LB466]

SENATOR CAMPBELL: Senator Howard. [LB466]

SENATOR HOWARD: I'm sorry. I have to ask you this. All right. Let's take an analogy and it's not an automobile analogy. [LB466]

SENATOR BLOOMFIELD: Thank you. (Laughter) [LB466]

SENATOR HOWARD: My dad was a Studebaker man. You have some problem. You need to have some heart surgery. There's a surgeon that's pretty good. You know he's had some problems but could have been somebody else's fault. You're going to go under the knife. You've got this guy out here that's really renowned; he's available to you, he can do it. Which direction are you going to go? [LB466]

SENATOR GLOOR: How do I know that? [LB466]

SENATOR HOWARD: I don't know. I'm asking you. [LB466]

SENATOR GLOOR: But that's the key. I mean, that really is the key. How do we know that? And I'd say what the state at least tries to put in place is to bring in a group of people who will sit down and take a look at those medications so they can tell us what works and what doesn't work. It would be to me...I would hope we get to the point some day where the state sits down, is able to do that with cardiologists for heart surgery to say, we can match these two up. They apparently currently do it with their PNT committee. [LB466]

SENATOR HOWARD: Well, I'm asking you though. This question is for you, that your advisory group is saying to you: you know, Mike, this guy, you know, he's pretty good. We had some concerns but, you know, like chances...you know, we think, you know, go ahead. And you're looking at this and your heart is not going to be in your hands; it's going to be in somebody else's. What are you going to do? [LB466]

SENATOR GLOOR: Well, I'm going to ask the same question. And that is, how do I know? How do I know this person is a bad practitioner and the other is a good practitioner? [LB466]

SENATOR HOWARD: I'm not saying he's bad. I'm not saying he's bad. [LB466]

SENATOR GLOOR: Okay. How do I know this person is...world renowned doesn't mean they're having good outcomes. [LB466]

SENATOR HOWARD: I'm not saying that either. I'm asking you what would you do. [LB466]

SENATOR GLOOR: Yeah, yeah. I would try and get the information to find out that very question. [LB466]

SENATOR CAMPBELL: Other questions for Senator Gloor or comments that you

wish...anyone wishes to make? Senator Bloomfield. [LB466]

SENATOR BLOOMFIELD: (Laugh) I'm going to make a statement. And that's when Senator Gloor is going to get tired of me because I'm going to ask him these questions until I understand what we're doing here before I vote on this issue. I may ask you on the floor. I may ask you in your office,... [LB466]

SENATOR GLOOR: I hope we get to the floor. [LB466]

SENATOR BLOOMFIELD: ...but I am going to have answers to these before I have to cast a vote on this because this is too important a thing to not understand,... [LB466]

SENATOR GLOOR: Yeah, it's very important. [LB466]

SENATOR BLOOMFIELD: ...and I don't at this point. [LB466]

SENATOR CAMPBELL: I would have to say, Senator Gloor and certainly for Mr. Winterer and the staff that are here, I under...and I appreciate that we are "grandfathering" the people in and, you know, that we've set up the appeals process. I have to tell you, I still might want more detail to what we're saving and not saving here. [LB466]

SENATOR GLOOR: I think that's a reasonable request. [LB466]

SENATOR CAMPBELL: And particularly in the discussion just in the last couple of minutes in the sense that if a committee is going to look at...they're going to bring together a committee of pharmacists and they're going to set this up, what they choose to put there or what their recommendations might be would very much determine what that final bottom line would be. I just don't...I'm not saying that you wouldn't ultimately save some money, but I question whether there needs to be certain pieces in place to know what that is. [LB466]

SENATOR GLOOR: Yeah. [LB466]

SENATOR CAMPBELL: And I may be way off-base, but at least it's a hint for what I'll probably be asking next week (laugh) in the committee because I...to make a step from any of the bills that we've heard and the ones that we're going to talk about next week that we came up with, I mean, these are big steps. They're making choices between A and B. Just want to make sure that when we say we're going to say "blank," that we have a fairly good idea that that's it. And maybe, you know, the department will come back and say, you know, Senator, that's the best we can do on the estimate. But at least I'll give them a heads up to let them know what my question is going to be because I don't want to go on a hope and a promise on some of these. [LB466]

SENATOR GLOOR: Yeah. And I would say my comfort level about those numbers, understanding that I don't think they're exact on the button,... [LB466]

SENATOR CAMPBELL: Right, right. [LB466]

SENATOR GLOOR: But the Milliman organization does a lot of this and I've had some personal experience with them with organizations I've been affiliated with, both acute care as well as insurance. But the bigger issue here and I know the head scratch...and I agree, I would like those numbers revisited also. But to me the reason that the number makes sense, that big number makes sense is, again, my...just that issue of knowing when clinicians who are prescribing have a chance to talk to people who are familiar with the latest in pharmacological science and are able to have this educational dialogue, it helps them, it helps the cost savings, and it helps the patients quite frequently. [LB466]

SENATOR CAMPBELL: Right. [LB466]

SENATOR GLOOR: And so it's reasonable to me that would happen a lot. [LB466]

SENATOR CAMPBELL: And, you know, in the Medicaid Reform Council we spent a lot of time looking at the whole...we talked about the medical or the model that came out of Missouri where, you know, they had a group of pharmacists that put together...and it probably mirrors what we've done here, but it'd be interesting to look at that. We're raising a lot of issues here for late,... [LB466]

SENATOR GLOOR: Yeah. [LB466]

SENATOR CAMPBELL: ...but at least it would give the department a heads up. Senator Wallman, did you have a question? I'm sorry. [LB466]

SENATOR WALLMAN: I better quit. (Laughter) [LB466]

SENATOR CAMPBELL: I don't want to ever see anybody quit. Just... [LB466]

SENATOR HOWARD: All right. It's his birthday. He can quit if he wants to. (Laughter) [LB466]

SENATOR CAMPBELL: Oh, my gosh. [LB466]

SENATOR GLOOR: Oh, that's right. [LB466]

SENATOR CAMPBELL: Where were the treats? [LB466]

SENATOR GLOOR: That's right. [LB466]

SENATOR CAMPBELL: (See also Exhibits 29-34) We're going to be talking to you, Senator Wallman. If there are no other comments or questions, I will close the hearing on LB466 and thank the audience for their patience and for their good testimony today. [LB466]